MEDICARE STATISTICAL FILES MANUAL

ALTH CARE FINANCING ADMINISTRATION
ce of Policy, Planning, and Research
A Pub. No. 018 (4-78)

Medicare Statistical Files Manual

This manual is prepared and maintained by the Statistical Data Systems Branch, of the Office of Statistics and Data Management, OPPR, HCFA under the direction of Eugene Stickler, Branch Chief.

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I. The Medicare Statistical System

Introduction

The purpose of this manual is to provide information about the various statistical files available within HCFA concerning the Medicare program. These files are maintained for HCFA by SSA. It is intended to provide people interested in the Medicare program with enough detail about each file so that they will be able to determine what data can be obtained. Each file is described in a separate chapter and includes an overall description of the file sample size, a list of "data fields" contained in each record, and a record layout.

To use this manual effectively it is helpful to have a basic understanding of the Medicare program and how it is administered. Described below is a brief description of the law and the administrative system.

Basic Provisions of Law

The 1965 amendments to the Social Security Act (Title XVIII) established two complementary health insurance programs for the aged -- a hospital insurance plan (Part A) and a supplementary medical insurance plan (Part B). The Part A plan provides coverage for hospitalizations, stays in skilled nursing facilities (nursing homes), and home health services. The Part B plan provides coverage for physicians' services, outpatient hospital services, home health services, and other medical services.

Benefit payments under both programs commenced July 1, 1966. Federally financed services in "skilled nursing facilities" began January 1, 1967. These benefits were available only to aged persons 65 and over.

The 1972 amendments to the act established coverage for persons disabled under age 65 (24 months or more continuously) and for persons with End Stage Renal Disease (ESRD). Their coverage began July 1, 1973.

The payment of hospital insurance benefits is geared to a benefit period (or "spell of illness"). A benefit period begins with the first day (not included in a previous benefit period) on which the individual is furnished inpatient hospital services or skilled nursing services and which occurs in a month for which he is entitled to hospital insurance protection. The benefit period ends with the close of the first period of 60 consecutive days thereafter on each of which he was neither an inpatient of any hospital nor an inpatient of any skilled nursing facility. There is no limit to the number of covered benefit periods the individual may have as long as he continues to be entitled to hospital insurance protection.

The Part A hospital insurance plan provides inpatient hospital services up to a maximum of 90 days for each benefit period. Patients pay a deductible for the first 60 days of care and a coinsurance amount for each day thereafter for each benefit period. Each beneficiary also has a lifetime reserve of 60 extra days of hospital care beyond the 90 days allowed for each benefit period. The patient, however, pays a portion of the charges for each of the additional 60 days.

Up to 100 days of care in a skilled nursing facility (SNF) for each benefit period is provided, but only after a hospital stay of three days or more and then only if the nursing facility meets certain conditions. The insurance covers the costs of the first 20 days of care, but the patient pays a daily coinsurance rate for the remaining 80 days. These benefits started in 1967.

The supplementary medical insurance plan (Part B) covers such items as physicians' and surgeons' services in or outside of the hospital, diagnostic X-Ray and laboratory tests, radium therapy, ambulance services, surgical dressings and other specific needs, and prosthetic devices. After a patient pays an annual deductible, medical insurance covers 80 percent of the remaining costs of covered services for that year. Effective April 1, 1968, the deductible and coinsurance do not apply to services furnished hospital inpatients by physicians in the fields of radiology and pathology and coinsurance does not apply to home health services after 1972. Beginning October 30, 1972, services performed in a laboratory that are billed on an assignment basis may be reimbursed at 100 percent of a negotiated rate not subject to the deductible or coinsurance. Unlike the hospital insurance plan, enrollment in the supplementary medical insurance program is voluntary; i.e., individuals must sign up and agree to pay a monthly contribution as set by law.

Fiscal Intermediaries

Under the hospital insurance program, intermediaries are selected by each institutional provider (hospitals, skilled nursing facilities, home health agencies) to act as the link between the provider and the Social Security Administration. A vital role of the intermediaries is to review and pay claims for the costs of providing care to the beneficiaries. The intermediary makes these payments to providers for covered items and services on the basis of reasonable cost determinations and assists in the application of safeguards against unnecessary utilization of covered services.

Under the supplementary medical insurance program, insurance carriers are selected by the Secretary of Health, Education and Welfare. The principal functions of these carriers are to determine the reasonable charges in their respective areas for each medical care service paid for under the program and to review and pay claims to or in behalf of beneficiaries for the services provided.

Hospital Insurance Claims Process

The hospital insurance claims process operation is essential to the objective of providing current benefit or utilization information to intermediaries. It also serves the purpose of controlling and monitoring intermediary payment to institutional providers. When a beneficiary is hospitalized, the participating provider notifies the intermediary of the admission, which in turn transmits the information as a query to SSA to ascertain the beneficiary's eligibility status.

SSA's Utilization Query and Reply Operations prepare the provider admission notices and other queries for subsequent processing in the update operations and also prepare replies (from the update) for transmitting back to intermediaries. Interim and final bills completed by hospitals, skilled nursing facilities and home health agencies are submitted to the intermediary. Based on this information and the information furnished by SSA in reply to an earlier query, the intermediary certifies payment to the provider.

The intermediary keys the information from the bills on magnetic tape, batches them in groups of up to 50 and forwards them to SSA. The taped bill records are processed through edit and batch control operations by SSA. Rejected bills are returned to intermediaries for correction and reinstatement (or voiding). Both bills and batches are held in the control system until their processing is completed or until they are deleted. Reports of batch processing and batch completion and of outstanding returned bills are sent to intermediaries at certain intervals for their use in reconciling batches submitted and in checking on bills to be corrected and returned to SSA. Records of the bills passing initial edits are passed on to the Beneficiary Master Update operation which records the transactions on the individual's HI Master record and also generates records for updating the Provider Master File and a history record of completed billing transactions. The update operation will also generate a beneficiary utilization notice where an interim or a final (discharge) bill is processed for inpatient services or home health visits.

Part A inpatient bill information is processed on an "in sequence" basis. This is determined from the billing dates, "From" and "To", present on each bill. Bills will be processed in "from" date sequence within a benefit period. A bill not related to a preceding open item (admission) will not be processed until the final bill for that open item is processed. All unprocessed bills are controlled, or placed in orbit, and any determination of a benefit period takes these unprocessed items into account, along with already processed, or recorded, items. (The HI Master record carries up to five of the most recent benefit periods in the beneficiary's record.) SSA's reply to an intermediary admission notice or query shows benefit days remaining and deductibles to be met as of the last recorded date of discharge or as of the last action, where there is an open item and interim billing has been received.

Medical Insurance Claims Process

A separate subsystem receives, edits and controls Part B outpatient bills, Part B home health agency bills and medical payment records. Part B outpatient bills and Part B home health agency bills are submitted from intermediaries while Payment Records are submitted from carriers. Processing differs from that for Part A bill records because, unlike Part A, Part B benefits are not tied to a benefit period with a limited number of days of care and varying coinsurance amounts. Under Part B, only physical therapy, psychiatric services and home health visits have an annual limitation on benefits payable.

Claims for payment of Part B benefits are submitted to the carrier or intermediary by beneficiaries or suppliers of the services (e.g., physicians). Where the carrier or intermediary queries SSA on the beneficiary's deductible status, the utilization query/reply operations handle the transaction similarly to Part A queries. Part B queries in addition update the Part B deductible, and record physical therapy and psychiatric expenses. Taking into account the beneficiary's deductible status, the carrier or intermediary determines and makes payment to the claimant.

Carriers submit Payment Records for all physician and supplier claims for which payment is made. They are batched and transmitted to SSA where they are edited, then matched against the HI Master record to check for beneficiary entitlement and, if appropriate, to record physical therapy or psychiatric services. A listing of rejected records is returned to carriers for corrections and the records are held, in the meantime, in a suspense record file. As records are corrected and returned, they are deleted from the suspense file. In addition, another operation controls the batches of payment records and provides statistical reports on bill processing by carrier.

Carriers submit to SSA monthly reports of monies paid during the month for SMI services. Batches of payment records are matched against these carrier financial reports to determine if submitted records of payments by carriers balance SSA's reimbursement to them for Part B payments made. Differences are to be reconciled by the Medicare Bureau, formerly the Bureau of Health Insurance.

SSA does not receive bills for Part B services rendered by certain Group Practice Prepayment Plans. They deal directly with SSA and are reimbursed on a per capita basis. An attempt was made in the statistical system to measure utilization by having these direct dealing GPPP's submit forms for each service rendered, however, this proved inadequate and is no longer operational. Deductibles for GPPP members (about 300,000) are updated by allocating one-twelfth of the deductible each month.

Exhibit A is a chart which shows the various Part A and Part B deductibles and coinsurance amounts and premiums required in the Medicare law and administered by SSA in the Health Insurance Administrative operations. The preceeding description contains only a brief review of the system. A more detailed description is available in "The Health Insurance System--A Narrative and Pictorial Description" published by Social Security Administration, Office of the Commissioner, OAS Pub. No. 010 (11/75).

The Statistical System

The primary objective of the statistical system of the Health Insurance Program is to provide data required to measure and evaluate the operations and the effectiveness of the two parts of the program. The benefit payment operations furnish the means of obtaining extensive, systematic, and continuous information about the amount and kind of hospital and medical care services used by Medicare enrollees, as well as the costs of such services. The applications of hospitals, skilled nursing facilities and home health agencies to participate in the Medicare program provide data on the characteristics of such providers of service. The claim number that is assigned to each enrollee serves as the link between the various services utilized under the program and the demographic characteristics of each individual recorded in the enrollment files.

The data-collection system has two inherent characteristics that determine to a considerable degree the scope, detail, and flexibility of the available data. First, data are collected and maintained on an individual basis so that the beneficiary and his medical experience under the program form the basic

unit. Second, records for each bill paid are maintained on a centralized basis. Except for intermediary operating statistics such as those relating to workloads, time lags, costs, and the like, all program statistics are centrally prepared.

The statistical system is based on three record systems which are byproducts of the Health Insurance Administrative operations. They are as follows:

1. The Health Insurance Master Enrollment Record

   This record identifies each person (aged and disabled) enrolled for Medicare. Data describing the characteristics of the Medicare enrolled population is obtained from this file. This file also serves as the basis for obtaining Medicare utilization rates.

2. Provider Master Record

   This file contains information on every hospital, skilled nursing facility, home health agency, independent laboratory and other institutional providers which must apply for participation in the program. Each is assigned a distinct provider number.

3. Utilization Records

   Part A and Part B billing information is maintained centrally and these records are tabulated monthly, quarterly and annually to measure the utilization of Medicare services. Since each record contains both the beneficiary's claim number and the provider's number, these records can be readily matched to the Enrollment and Provider records. By this process statistical records can be created that contain all the available information needed for tabulation from the three files.

In addition to the one hundred percent utilization files described above, there are sample files for which diagnostic and surgery codes are obtained centrally at SSA. These are summarized in the following table:

Medicare Sample Sizes for Diagnosis and Surgical Procedure Coding

Type of Medicare Benefit	Billing Form	Sample Size	Remarks
Inpatient Hospital	SSA-1453	20%	
Skilled Nursing Facility (SNF)	SSA-1453	100%	
Medical & Other Health Services (Outpatient Hospitals)	SSA-1483	5%	For services in 1971 or later
		20%	From July 1968 thru services in 1970.
		40%	From July 1966 - June 1968
Home Health Agency - Part A and Part B	SSA-1487	40%	Part A was 100% to May 1969

Diagnostic Coding for Services thru 1970 - ICDA 7
Diagnostic Coding for Services after 1970 - ICDA 8
Surgical Procedure Coding for all years - CPT

The remaining chapters of this manual describe in detail the projects, tabulations and files based on the basic record systems discussed above. It should be mentioned, however, that these are not the only sources of Medicare information used by the Office of Statistics and Data Management of HCFA. Files for non-recurrent projects are prepared regularly in order to provide information on the Medicare program to Congress, outside researchers and analysts in HCFA. The Office of Demonstrations and Evaluations collects data usually direct from the source for experiments which they conduct. These files are beyond the scope intended for this manual. For further information on these special files contact the Office of the Associate Administrator, Office of Policy, Planning, and Research, HCFA.

HI-SMI Deductibles, Coinsurance and Premiums

Part A

	Year in Which Benefit Period Begins										
	1966-68	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978
Premium 1/	NA	NA	NA	NA	NA	$33	$36	$40	$45	$54	$63
Inpatient Hospital Deductible	$40	$44	$52	$60	$68	$72	$84	$92	$104	$124	$144
Inpatient Hospital Coinsurance 61st-90th day	$10	$11	$13	$15	$17	$18	$21	$23	$26	$31	$36
Inpatient Hospital Lifetime Reserve (60 days) 5/	$20	$22	$26	$30	$34	$36	$42	$46	$52	$62	$72
Inpatient Hospital Blood Deductible	3 pts	3 pts	3 pts	3 pts	3 pts	3 pts	3 pts	3 pts	3 pts	3 pts	3 pts
SNF Coinsurance 21st-100th day	$5	$5.50	$6.50	$7.50	$8.50	$9	$10.50	$11.50	$13	$15.20	$18
Outpatient Hospital Deductible for Diagnostic Services (Part A)	$20	(NA after 03/31/68-$20 for each 20 day diagnostic study period before 04/01/68)									

Part B

	1966-67	1968-69	1970	1971	1972	1973	1974-75	1976	1977	1978
Premium 1/	$3	$4 2/	$5.30	$5.60	$5.80	$6.10/ 6.30 3/	$6.70	$7.20	$7.70	$8.20
Deductible	$50	$50	$50	$50	$50	$60	$60	$60	$60	$60
Coinsurance	20%	20%	20%	20%	20%	20% 4/	20%	20%	20%	20%
Blood	NA	3 pts	3 pts	3 pts	3 pts	3 pts	3 pts	3 pts	3 pts	3 pts

1/ Changes in premium from one year to the next are effective July 1, unless otherwise indicated.
2/ Raised to $4 04/68.
3/ Raised to $6.10 on 08/73 and then to $6.30 on 09/73.
4/ Does not apply to HHA services. NA to some IL services.
5/ Effective 04/01/68.

02/78

Exhibit A

II. Enrollment

Introduction

This chapter describes the files used to obtain data on the total Medicare population and also various subpopulations of persons enrolled for Medicare benefits.

The Health Insurance Master File (HIM)

The Health Insurance Master File (HIM) identifies each aged and disabled person entitled to Medicare benefits and indicates whether he is entitled to hospital insurance benefits, supplementary insurance benefits or both. Data on age, sex, race and place of residence are obtained from this file.

For each person eligible for Medicare benefits, a record is maintained in the HIM file. Identification of each record is based on the persons Social Security or Railroad Retirement Board claim number and a one or two position beneficiary identification code (BIC). The BIC portion of the claim number describes the type of benefit that entitles individuals to Medicare coverage. The type of benefit and related BIC are described in Exhibit A.

The HIM file is updated daily for current maintenance and utilization information. Maintenance data consists of beneficiary enrollments and terminations, cross-references, changes of address and field changes which are received from the master beneficiary record (MBR) system of SSA and the Railroad Retirement Board. Utilization data consists of notices of hospital admissions, queries, provider billing records, and payment records received from intermediaries and carriers. Both the utilization and maintenance data are matched to the HIM for updating as part of SSA's administrative process. This is illustrated in Chart 1.

Health Insurance Skeleton Eligibility Writeoff File (HISKEW)

To tabulate enrollment data a skeletonized version of the HIM file known as the Health Insurance Skeleton Eligibility Writeoff (HISKEW) is created. The HISKEW file is produced quarterly from the HIM file and is assigned an operation date which is the last month of the quarter, i.e., for the first quarter of 1976, the operation date would be March 1976. This date is used to reference the HISKEW file to be used as input for the tabulation of enrollment data. A record format of this file which includes a description of each field is shown in Exhibit B.

Annual Enrollment Publication Tables

The annual enrollment tabulations showing the number of persons enrolled as of July 1 and the number of persons enrolled at any time in the year, are produced from the HISKEW file created as of March of the following year. For example, 1976 data is produced from the March 1977 HISKEW file.

The tabulations contain counts of aged and disabled enrollees by:

1. Type of coverage (HI, SMI, or both)

2. Age, race, and sex

3. State of residence (See Exhibit C for Standard State Codes)

4. Residence in Standard Metropolitan Statistical Areas and Metropolitan and Non-Metropolitan counties

5. The number of persons that have been newly enrolled or terminated during the year of the data.

In addition to the above, enrollees by county are shown as part of a publication containing enrollment and Medicare reimbursement by State and county. We also tabulate annual and quarterly data which is used for text tables, control tables and utilization rates but are not routinely published.

Special Population Groups

1. Railroad Retirement Board -- A file of RRB beneficiaries entitled to Part A and/or Part B coverage is developed each year from the March HISKEW file. Enrollees are selected for this file based on RRB claim number or a dual entitlement indicator. The entire HISKEW record is retained for each person selected. The file is used to obtain control data and can also be used to select records to study utilization of RRB enrollees.

2. State Buy-In Enrollment -- A state, through a buy-in agreement with SSA, may enroll needy, aged and disabled persons eligible for either public assistance or medical assistance programs for Part B coverage. Once buy-in eligibility in these programs is established, enrollment of an individual is involuntary on the part of the person even though he does not wish to enroll or has enrolled individually for Part B coverage; neither can he voluntarily terminate this coverage. A record for each enrollee is maintained in the SSA Third Party Master file.

This file is updated from records submitted by the State to SSA of individuals to be added to or deleted from its coverage group. Those records to be added to the group are screened against the HIM file to determine if the person is eligible for Part B benefits. Matched records are annotated to indicate buy-in status in the HIM file, added to the Third Party Master file, and billing to the State is initiated.

Each year a State buy-in membership "ever enrolled" file population is developed from the Third Party Master file. Records are selected for this file if a person is a buy-in at any time in the specified calendar year. For each person selected, a record is created containing the following information:

1. HI claim number

2. Date of birth

3. Sex

4. Race

5. State of Residence at time file is created

6. Cross-reference claim number

7. Buy-in plan start date and;

8. Termination date

The file is summarized by age, race, sex, and State of Residence. Tables are prepared presenting these data based on the number of buy-ins enrolled at any time in a year and as of July 1 of each year.

Group Practice Prepayment Plans (GPPP's)

The Group Health Plan System (GHP) maintains a membership file for GPPP's which deal directly with SSA for purposes of reimbursement and of control of posting of deductible pro-rata amounts of each plan member entitled to Part B coverage. Reimbursement to each plan for Part B services rendered each member is based on a cost basis for GPPP's dealing directly with SSA. A file of enrollees by plan is maintained in the Group Health Plan Master Record file (HCGPMSTER).

The HCGPMSTER file is updated by records submitted to SSA by a GPPP. Each record is screened for Part B eligibility against the HIM file and processed in the HCGPMSTER file.

Annual Enrollment data are developed only for those plans dealing directly with SSA. Records are selected from the HCGPMSTER file containing the following information:

1. HI claim number

2. Date of birth

3. Sex

4. Race

5. State of Residence at time file is created

6. Cross-reference claim number

7. Plan start date

8. Termination date and;

9. GPPP plan number

This information is summarized by age, race, sex, GPPP plan and State of Residence. Tables are prepared presenting data on the number of persons enrolled at any time in a year and as of July 1 of each year.

Chart 1.--Health Insurance Master Beneficiary Record--Enrollment and Utilization Maintenance

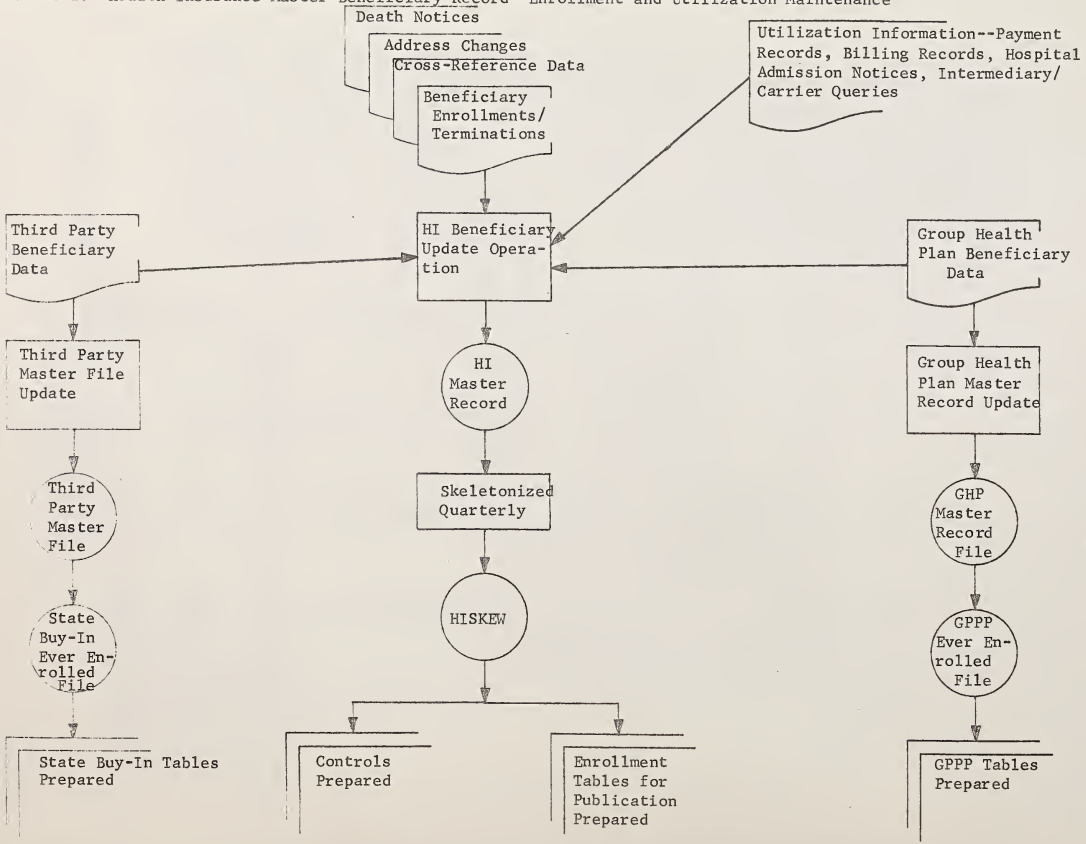

Exhibit A

Beneficiary Identification Codes
SSA Type of Claim

	1st Claimant	2nd Claimant	3rd Claimant	4th Claimant	5th Claimant
Wage Earner	A				
Wife age 62 or older	B	B3	B8	BA	BD
Wife under age 62	B2	B5	B7	BK	BL
Divorced wife	B6	B9	BN	BP	BQ
Child (including disabled or student child)	C (Oldest child will have highest subscript; subscripts will descend to C1 for youngest child)				
Widow age 60 or older	D	D2	D8	DD	DG
Widow remarried after age 60	D4	D9	DA	DL	DN
Surviving divorced wife	D6	D7	DV	DW	DY
Mother	E	E2	E7	E8	EA
Surviving divorced mother	E1	E3	EB	EC	ED
Husband age 62 or older	B1	B4	BG	BH	BJ
Widower age 60 or older	D1	D3	DH	DJ	DK
Widower remarried	D5	DP	DQ	DR	DT
Father	E4	E6	EF	EG	EH
Surviving divorced father	E5	E9	EJ	EK	EM
Father	F1	F7			
Mother	F2	F8			
Stepfather	F3				
Stepmother	F4				
Adopting father	F5				
Adopting mother	F6				
Entitled to HIB (less than 3 QC's)	J1				
Entitled to HIB (3 QC's or more)	J2				
Not entitled to HIB (less than 3 QC's)	J3				
Not entitled to HIB (3 QC's or more)	J4				
Wife entitled to HIB (less then 3 QC's)	K1	K5	K9	KD	KH
Wife entitled to HIB (3 QC's or more)	K2	K6	KA	KE	KJ
Wife not entitled to HIB (less than 3 QC's)	K3	K7	KB	KF	KL
Wife not entitled to HIB (3 QC's or more)	K4	K8	KC	KG	KM
Black lung miner	LM				
Black lung miner's widow	LW				
Uninsured (not entitled to HIB, qualified for SMIB)	M				

	1st Claimant	2nd Claimant	3rd Claimant	4th Claimant	5th Claimant
Uninsured (qualified for HIB, but requested only SMIB)	M1				
Uninsured (entitled to HIB under deemed insured provision)	T				
Disabled widow	W	W2	W4	W9	WF
Disabled widower	W1	W3	W5	WB	WG
Disabled surviving divorced wife	W6	W7	W8	WC	WJ

RRB Type of Claim

10	Retirement - Employee or annuitant
80	RR Pensioner (age or disability)
14	Spouse of RR employee or annuitant (husband or wife)
84	Spouse of RR pensioner
43	Child of RR employee
13	Child of RR annuitant
17	Disabled adult child of RR annuitant
46	Widow or widower of an RR employee
16	Widow or widower of an RR annuitant
86	Widow or widower of an RR pensioner
43	Widow of employee with a child in her care
13	Widow of annuitant with a child in her care
83	Widow of pensioner with a child in her care
45	Parent of RR employer
15	Parent of RR annuitant
85	Parent of RR pensioner
11	Survivor Joint Annuitant - An annuitant who has taken a reduced amount to guarantee payments to a surviving spouse.

Exhibit B

HISKEW Record Format

	Information	Number of Positions	Positions BEG	Positions END	Description
1.	Claim Number	9	1	9	SSA account number, which is all numeric, or a RRB number, which is non-numeric in the first position (hundreds position of area), under which record is currently housed in the file.
2.	Beneficiary Identification Code (BIC)	2	10	11	SSA or RRB type of claim and subscript (see Exhibit A for possible codes and their meanings).
3.	Date of Birth	5	12	16	YYDDD-Julian date of beneficiary's birth
4.	Sex Code	1	17	17	0-Unknown 1-Male 2-Female
5.	Race Code	1	18	18	0-Unknown 1-White 2-Negro 3-Other
6.	State Code	2	19	20	SSA standard state coding system (see Exhibit C for possible codes and their meanings) 1/
7.	County Code	3	21	23	SSA standard county coding system (3 position numeric, 999 for unknown) 1/
8.	Cross-referred	11	24	34	Claim number associated with the beneficiary other than the one under which the record is currently housed in the file.
9.	Data Code 1	1	35	35	0-All off 1-State buy-in 2-Dual involvement-RRB 3-Both conditions present
10.	Data Code 2	1	36	36	0-All off 1-Previous DIB
11.	Data Code 3	1	37	37	0-All off 1-CRD spouse or child of worker

	Information	Number of Positions	Positions BEG	Positions END	Description
12.	Data Code 4 (Original Reason for Entitlement)	1	38	38	0-OASI 1-DIB (HR-1) 2-Renal 3-Both DIB and Renal
13.	Data Code 5 (Current Reason for Entitlement)	1	39	39	0-OASI 1-DIB (HR-1) 2-Renal 3-Both DIB and Renal
14.	Data Code 6	1	40	40	0-All off 1-Prior or current HMO member
15.	Dual Entitlement	1	41	41	0-Not dually entitled 1-Dually entitled
16.	Previous BIC	2	42	43	Indicates any previous type benefits paid to beneficiary (see Exhibit A for possible codes and their meanings).
17.	Date of Death	5	44	48	YYDDD-Julian date of beneficiary's death
18.	Current Part A Data a. Entitlement	5	49	53	YYDDD-Julian date of entitlement. Zeroes indicate no Part A entitlement.
	b. Termination	5	54	58	YYDDD-Julian date of termination. Zeroes indicate no Part A termination date. Nines indicate erroneous entitlement or date not known.
19.	Current Part B Data a. Entitlement	5	59	63	Zeroes indicate no Part B entitlement.
	b. Termination	5	64	68	YYDDD-Julian date of termination. Zeroes indicate no Part B termination date. Nines indicate erroneous entitlement or date not known.

	Information	Number of Positions	Positions BEG	END	Description
20.	Coverage Code	1	69	69	0-No coverage or dead 1-Part A entitlement only 2-Part B entitlement only 3-Part A and Part B entitlement
21.	Termination Code A	1	70	70	⌀-Not terminated 1-Dead 2-Non-payment of premium 3-Voluntary withdrawal 4-Entitlement under another claim number 9-Other termination
22.	Termination Code B	1	71	71	⌀-Not terminated 1-Dead 2-Non-payment of premium 3-Voluntary withdrawal 4-Entitled under another claim number 9-Other termination
23.	Ledger Account File Code (LAF)	2	72	73	Indicates benefit payment status and reason for such status.
24.	Prior Part A Data a. Entitlement	5	74	78	YYDDD-Julian date of entitlement. Zeroes indicate no prior Part A entitlement.
	b. Termination	5	79	83	YYDDD-Julian date of termination. Zeroes indicate no prior Part A termination. Nines indicate erroneous entitlement or date not known.
25.	Prior Part A Option	1	84	84	Prior HIB enrollment option code.
26.	Prior Part B Data a. Entitlement	5	85	89	YYDDD-Julian date of entitlement. Zeroes indicate no prior Part B entitlement.
	b. Termination	5	90	94	YYDDD-Julian date of termination. Zeroes in-

	Information	Number of Positions	Positions BEG	END	Description
26.	b. Termination (con't)				dicate no prior Part B termination. Nines indicate erroneous entitlement or date not known.
27.	Prior Part B Option	1	95	95	Prior SMIB enrollment option code.
28.	Source Code	1	96	96	1-Mail enrollment 2-Field filing
29.	Current Part A Option	1	97	97	HIB enrollment option code.
30.	Current Part B Option	1	98	98	SMIB enrollment option code.
31.	Previous Coverage	1	99	99	0-Fewer than 3 SMI coverage periods 1-More than 2 SMI coverage periods
32.	Bill Code	1	100	100	1-Individual 2-Public Assistance 3-Private Third Party 4-Civil Service
33.	ZIP Code	5	101	105	Beneficiary's ZIP Code
34.	Day 01 Indication	1	106	106	0-Not applicable 1-Beneficiary born on first day of month
35.	Chronic Renal Disease Indication (CRDI)	1	107	107	A-MBR Notice of CRD B-HI Notice of CRD C-NIH Notice of CRD D-MBR and HI Notice of CRD E-MBR and NIH Notice of CRD F-HI and NIH Notice of CRD G-MBR, HI, and NIH Notice of CRD

	Information	Positions	Positions BEG	Positions END	Description
36.	Recode Field	2	108	109	For future use
37.	Filler	11	110	120	Blanks

1/ State and county codes for railroad records (account numbers beginning with 5-G) will conform to those in "Geographic Codes for State and County of Residence" (SSA Pub. 69-26).

SSA Standard State Coding System

	State Code
All Areas 1/	
United States 2/	
Regions	
Northeastern States	
North Central States	
South	
West	
Divisions	
New England	
Middle Atlantic	
East North Central	
West North Central	
South Atlantic	
East South Central	
West South Central	
Mountain	
Pacific	
States	
Alabama	01
Alaska	02
Arizona	03
Arkansas	04
California	05
Colorado	06
Connecticut	07
Delaware	08
District of Columbia	09
Florida	10
Georgia	11
Hawaii	12
Idaho	13
Illinois	14
Indiana	15
Iowa	16
Kansas	17
Kentucky	18
Louisiana	19
Maine	20
Maryland	21
Massachusetts	22
Michigan	23
Minnesota	24
Mississippi	25
Missouri	26
Montana	27
Nebraska	28
Nevada	29
New Hampshire	30
New Jersey	31
New Mexico	32
New York	33
North Carolina	34
North Dakota	35
Ohio	36
Oklahoma	37
Oregon	38
Pennsylvania	39
Rhode Island	41
South Carolina	42
South Dakota	43
Tennessee	44
Texas	45
Utah	46
Vermont	47
Virginia	49
Washington	50
West Virginia	51
Wisconsin	52
Wyoming	53
Residence Unknown	
Outlying Areas	
Guam	65
Puerto Rico	40
Virgin Islands	48
Other Outlying Areas 3/	63, 64 65, 48
Foreign Countries	
Foreign Countries	54-62

1/ All areas is the total of United States, residence unknown, outlying areas, and foreign countries.
2/ United States is the total of all states and residence unknown.
3/ Other outlying areas is the total of Guam, Virgin Islands, and other outlying areas.

III. The Query System--Admission Notice

Introduction

SSA has the basic responsibility for controlling and monitoring intermediary/carrier payments to beneficiaries or providers. Intermediaries and carriers are responsible for verifying a beneficiary's eligibility, type of coverage, deductible, etc., before a claim is paid. When a beneficiary is hospitalized, the provider notifies the intermediary of the admission, which in turn, transmits the information as a query to SSA to ascertain the beneficiary's eligibility status. SSA's query system processes these queries against its Health Insurance Master file to determine the beneficiary's status. If the beneficiary is covered, SSA will then prepare an admission notice for in-house subsequent processing and will also transmit a query reply that is used by the intermediary to update its own history files.

Preparation of the Query Record

A query (admission) record must be submitted by a provider through the intermediary for all Medicare beneficiary admissions. This is needed by SSA to maintain accurate benefit period (spell-of-illness) information. In addition to inpatient or skilled nursing facility (SNF) admissions, a start of care notice is required by SSA when participating home health agency services are utilized.

The notice of an inpatient hospital admission, when transmitted to SSA, results in recording the beginning of services in the patient's utilization record; i.e., the creation of an "open item" record. This open item remains on the individual's record until it is closed by a discharge bill. See Exhibit A for complete contents of the Admission Record.

Queries are also received by SSA for Supplementary Medical Insurance (SMI) claims. However, after the carrier has verified the beneficiary's entitlement and deductible status, if the deductible is met, subsequent claims are not normally queried. SMI claims involving non-inpatient psychiatric or physical therapy expenses must be queried unless the carrier has information in file from a previous reply indicating that the applicable money limits have been reached. Since current statistics are not being obtained from SMI queries, this manual does not cover those records.

Exhibit A

Part A (Query) Admission Notice Contents

	Information	Number of Positions	Location BEG	Location END	Description
1.	Original Record Length	5	1	5	Constant 00114
2.	Beneficiary Claim Number				
	a. CAN	9	6	14	
	b. BIC	2	15	16	
3.	Record Identification Code	1	17	17	Constant 'J'
4.	Admission Date	5	18	22	YYDDD-Year and Julian date beneficiary admitted as inpatient or start of care for HHA services.
5.	Administrative Field	8	23	30	Not used in statistical operations.
6.	Query Code	1	31	31	1-Initial request 2-Delete previous request 4-Follow-up request 5-Status request
7.	Administrative Field	4	32	35	Not used in statistical operations.
8.	Beneficiary Name				
	a. Surname	6	36	41	
	b. First Initial	1		42	
	c. Middle Initial	1		43	
9.	Date of Birth	5	44	48	YYDDD-Field will contain zeroes if unknown.
10.	Sex Code	1	49	49	0-Unknown 1-Male 2-Female
11.	Transaction Code	1	50	50	Type of Facility 0-Christian Science SNF 1-Psychiatric 2-TB 3-General Care 4-Regular SNF 5-Home Health
12.	Administrative Field	2	51	52	Not used in statistical operations.
13.	Receipt Date	5	53	57	YYDDD-Date admission notice was received into the EDP system.

	Information	Number of Positions	Location BEG	END	Description
14.	Process Date	5	58	62	YYDDD-Date admission notice was processed by the HDHIDUP operation.
15.	Administrative Field	4	63	66	Not used in statistical operations.
16.	Disposition Code	2	67	68	This code identifies the type of reply made by SSA to the intermediary. Codes basically indicates approval, rejection, qualified approval, or just an acknowledgement of the receipt of the admission notice.
17.	Administrative Field	8	69	76	Not used in statistical operations.
18.	Reason for Entitlement Trailer Code	1	77	77	0-No disability or ESRD involvement 1-Beneficiary currently insured due to disability. No ESRD involvement. 2-Beneficiary currently insured due solely to ESRD. 3-Beneficiary currently insured for disability with prior or current ESRD involvement. 4-Beneficiary currently insured due to age (OASDI) with prior or current ESRD involvement. 8-Beneficiary currently entitled to Part A coverage due to buy-in provisions with prior or current ESRD involvement.
19.	Administrative Field	21	78	98	Not used in statistical operations.
20.	Intermediary Number	5	99	103	Intermediary's identification number.
21.	Provider Number	6	104	109	Identification number of provider of services.

	Information	Number of Positions	Location BEG	END	Description
22.	Blank	5	110	114	Reserved for future use.

IV. Bill Records from Institutional Providers

Introduction

This chapter describes the statistical files created from bills submitted from institutional providers. These providers provide Medicare services for both Part A and Part B of the program. They submit their bills to SSA by way of the Part A intermediary which they have selected.

One Hundred Percent Files

Provider bills submitted by intermediaries to SSA enter the statistical system only after they have been updated to the Health Insurance Master Record (HIM). When the bill records are updated to the Master Record, the enrollees demographic characteristics such as age, sex, race and residence are appended. These records, which now contain both billing and demographic information are cumulated weekly and then entered into the statistical system.

Exhibits A, B, and C contain copies of the principal billing forms and their related bill records which comprise the one hundred percent bill files. They are as follows:

Exhibit A - Inpatient Hospital and Extended Care Bill (Form SSA-1453). This record contains information from Part A inpatient hospital and inpatient skilled nursing facility bills.

Exhibit B - Home Health Agency Bill (Form SSA-1487). This record contains Part A and Part B HHA billing information. If a bill contains both Part A and Part B information, two separate tape records are prepared.

Exhibit C - Provider Billing for Medicare and Other Health Services (Form SSA-1483). This record contains Part B Outpatient Billing Information.

The one hundred percent provider bill files along with the one hundred percent file of payment records (see Chapter V) are used to prepare control tables and a series of monthly, quarterly, semiannual and annual tabulations. Exhibit D contains an index of these tabulations and a brief description of their contents. Some tables are based on all of the records and others are based on samples which are inflated. The remaining chapters of this manual describe some of the annual tabulations and the summary records produced from them.

Sample Files Containing Diagnosis and Surgical Procedure Codes

In addition to the one hundred percent utilization bill files described above, there are sample files for which diagnostic and surgical procedure codes are obtained. These are coded centrally by HCFA based on the narrative descriptions contained in the various billing forms. The table in Exhibit E summarizes the coding samples. The information coded on each type of bill is as follows:

Inpatient Hospital - Primary discharge diagnosis and primary surgical procedures (if any).

Inpatient SNF - Primary admitting diagnosis.

Outpatient Hospital - Primary nature of illness and primary surgical procedure.

Home Health Agency (A or B) - Primary diagnosis.

In all cases, HCFA also codes an indication (yes, no or unknown) of whether additional diagnoses or surgical procedures are indicated on the bill.

Prior to 1977 most intermediaries submitted hard copy bills to SSA and coding was done manually. Now all intermediaries send billing and diagnostic-surgical information to SSA on magnetic tape. Codes are entered into the billing record through a process known as the Automated Medical Coding System (AMCS). This system involves the computer coding of diagnoses and surgical procedures and a clerical procedure for those items not coded by computer. A brief description of how the AMCS works is as follows:

1. Intermediaries key the narrative diagnostic and surgical procedure information along with all of the other billing items. Up to 45 characters are keyed for diagnosis and 41 for surgery. This Bill Record is submitted to SSA on magnetic tape.

2. The keyed narrative (available on sample bills only) is split off by SSA along with identifying information to allow it to be matched back to the proper Bill Record. This new record called the Coding Record is processed through the AMCS. Exhibit F contains the contents of the Coding Record.

3. The Coding Record is matched to a dictionary which contains diagnostic terms and their codes. When there is a match the code from the dictionary is applied to the Coding Record. This record is later matched back to the bill and the code entered into the Bill Record. When there is no match, a proposed code is assigned and the list of narratives and their proposed codes are sent for review by trained coders. The coders either accept the proposed code or enter the correct code next to it. These items are then keyed with the correct code and identifying information and matched back to the Bill Record.

4. Periodically the dictionary is updated adding new terms to it.

5. For surgical procedures, the identical process as was used for the diagnostic codes is done.

INPATIENT HOSPITAL AND SKILLED NURSING FACILITY ADMISSION AND BILLING

HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

Exhibit A
Form Approved
OMB No. 72-R0734

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

1. Patient's last name	First name	MI	2. Sex ☐M ☐F	3. Health insurance claim number
4. Patient's address (Street number, City, State, ZIP Code)			5. Date of birth	6. Medical record number
7. Date of this admission	8. Provider name and address (City and State)		9. Provider number	10. Attending physician
11. Dates of qualifying stay FROM / THRU	12. Qualifying and other prior stay information			

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to them upon their request, complete items 13 and 14.

13. Insuring organization and / or State agency name and address	14. Policy and / or medical assistance number

15. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

☐ Contained in provider's record	Signature (Patient or authorized represe tative) (Signature by mark must be witnessed)	Date

16. Admitting diagnoses (If employment related, also give name and address of employer)	Do not use this space	17. Discharge or current diagnoses (a) Primary (b) Secondary	Do not use this space
18. Surgical procedures (Show date of each)			

19. STATEMENT OF SERVICES RENDERED	Blood pints furnished	Pints replaced	Not replaced	Charge per pint	Total Charges	Non-covered Chg's.
A. Accommodation			Days	Rate		
B. 1-Bed						
C. 2-3-4 Bed						
D. 5 or more Beds						
FOR HOSPITAL ONLY E. Intensive care						
F. Coronary care						
G.						
H. Operating room						
I. Anesthesia						
J. Outpatient services						
K. Blood administration						
L. Pharmacy						
M. Radiology						
N. Laboratory						
O. Medical, surgical and central supplies						
P. Physical therapy						
Q. Occupational therapy						
R. Speech pathology						
S. Inhalation therapy						
T. Other (Describe)						
U. TOTALS						
V. Inpatient deductible						
W. Blood deductible pts. @						
X. Coinsurance days ( ) ( )						
Y. TOTAL DEDUCTIONS						

20. Statement covers period FROM	THRU
21. Date guarantee of payment began	22. Date UR notice received
23. Date active care ended	24. Date benefits exhausted

25. Patient status

A. Date discharged	B. Date of death	C. ☐ Still patient

26. Lifetime reserve days used	27. Non-covered days	28. Covered days

30. Remarks:

PIP (a) ☐

31. Reimbursement amount $

FOR INTERMEDIARY USE

32. Verified non-covered stays From / Thru	33. Non-pmt. code	34. Days used

29. I certify that the required physician's certification and recertifications are on file.

Signature of provider representative	Date received	35. Approved by	Date approved

FORM SSA-1453 (5) (10-74)

Department of Health, Education, and Welfare
Social Security Administration

Inpatient Hospital and SNF Bill Record

	Information	Dec. Size	Usage 1/		Location	Description
1.	Record Length	4	C3	3	1-3	Constant 560.
2.	Beneficiary Claim Number					
	a. CAN--Social Security Number	9	X	9	4-12	
	b. BIC--Type of Beneficiary	2	X	2	13-14	
3.	Record Identification Code	1	X	1	15	V-Inpatient Part A, SNF Part A, or Christian Science Part A.
4.	Statement Covers Period From Date	5	C3	3	16-18	YYDDD beginning date of stay. Item 20 SSA Form 1453.
5-8.	Administrative Fields	12	C3	10	19-28	Not used in statistical operations.
9.	Name					
	a. Surname	6	X	6	29-34	
	b. First Initial	1	X	1	35	
	c. Second Initial	1	X	1	36	
10-11.	Administrative Fields	6	C3	4	37-40	Not used in statistical operations.
12.	Query Code	1	X	1	41	Code indicating status of bill 1-Interim bill 3-Final bill 5-Debit adjustment 0-Credit adjustment
13-19.	Administrative Fields	33	C3	27	42-68	Not used in statistical operations.
20.	Original, Corrected or Cross-Reference No.					
	a. Account Number	9	X	9	69-77	
	b. BIC	2	X	2	78-79	
21-24.	Administrative Fields	68	C3	67	80-146	Not used in statistical operations.
25.	Transaction Code	1	X	1	147	0-Christian Science SNF 1-Psychiatric hospital facility 2-Tuberculosis hospital facility 3-General care hospital facility 4-Regular SNF

	Information	Dec. Size	Usage	1/	Location	Description
26-27.	Administrative Fields	2	X	2	148-149	Not used in statistical operations.
28.	Intermediary Number	5	X	5	150-154	Identification number of intermediary processing bill.
29.	Batch Number					
	a. Sequence Number	4	X	4	155-158	Control number assigned to batch by intermediary.
	b. Julian Date	4	X	4	159-162	YDDD-Julian date batched by the intermediary.
30.	Master Block Number					
	a. Julian Date	4	X	4	163-166	YDDD-Julian date blocked by SSA-7005.
	b. Block Number	3	X	3	167-169	A three digit block number indicates type of bills.
	c. Unit Number	1	X	1	170	A one digit unit number.
31.	Sequence Number	2	X	2	171-172	Sequence number 01-55 assigned to bill (signed +) 77-Adjustment bill 88-Over 55 bills to a batch 99-Incomplete bill
32-36.	Administrative Fields	8	X	8	173-180	Not used in statistical operations.
37.	Medicare Status Code	2	X	2	181-182	~~00~~-Unknown 10-Aged without CRD 11-Aged with CRD 20-Disabled without CRD 21-Disabled with CRD 31-CRD only
38.	Provider Identification Number	6	X	6	185-190	Item 9. Provider number on bill.
39.	Statement Covers Period Through Date	5	C3	3	191-193	Form SSA-1453--Item 20 YYDDD-Ending date of stay.
40.	Reimbursement Amount	8	C3	5	194-198	$$$$$$cc-Reimbursement amount for bill. Form SSA-1453--Item 31.
41.	Date of Admission	5	C3	3	199-201	YYDDD-Form SSA-1453--Item 7. Indicates date of admission for inpatient stay.
42.	Dates of Qualifying Stay					Form SSA-1453 (SNF)--Item 11 Dates of qualifying stay for SNF facility.
	a. From Date	5	C3	3	202-204	YYDDD-Beginning date of stay
	b. Through Date	5	C3	3	205-207	YYDDD-Ending date of stay

	Information	Dec. Size	Usage 1/		Location	Description
43.	Admitting Diagnosis Code	5	X	5	208-212	Code indicating primary admitting diagnosis on admission. Form SSA-1453 only (SNF Item 16).
44.	Discharge Diagnosis	5	X	5	213-217	Code indicating primary discharge diagnosis at discharge. Form SSA-1453 only, Item 17.
45.	Surgical Procedures Date	5	C3	3	218-220	YYDDD-Date on which surgical procedures were performed. If entry in surgical procedures but no date is shown, zeroes are used. Blank if no surgical procedures entry. Form SSA-1453 only (Inpatient) Item 18.
46.	Surgical Procedures Code	5	X	5	221-225	Code indicating type of surgery performed. Blank if no code shown. Form SSA-1453 only (Inpatient) Item 18.
47.	First Accommodation					Code indicating line entry Form SSA-1453 (Inpatient or SNF) Item 19.
	a. Accommodation Code	1	X	1	226	B-1 bed C-2, 3, 4 beds D-5 or more beds E-Intensive care F-Self care G-PIP total
	b. Number of Days	3	C3	2	227-228	Number of days in stay.
	c. Total Charges	8	C3	5	229-233	$$$$$$¢¢-Charges for accommodation.
	d. Non-Covered Charges	8	C3	5	234-238	$$$$$$¢¢-Non-covered charges for accommodation.
48.	Second Accommodation					Form SSA-1453 (Inpatient or SNF) Item 19.

	Information	Dec. Size	Usage 1/		Location	Description
	a. Accommodation Code	1	X	1	239	B-1 bed C-2, 3, 4 beds D-5 or more beds E-Intensive care F-Self care
	b. Number of Days	3	C3	2	240-241	Number of days in stay.
	c. Total Charges	7	C3	4	242-245	$$$$¢¢-Charges for accommodation.
	d. Non-Covered Charges	7	C3	4	246-149	$$$$$$¢¢-Non-covered charges for accommodation.
49.	Third Accommodation					Form SSA-1453 (Inpatient or SNF) Otem 19.
	a. Accommodation Code	1	X	1	250	B-1 bed C-2, 3, 4 beds D-5 or more beds E-Intensive care F-Self care
	b. Number of Days	3	C3	2	251-252	Number of days in stay.
	c. Total Charges	7	C3	4	253-256	$$$$$¢¢-Charges for accommodation.
	d. Non-Covered Charges	7	C3	4	257-260	$$$$$¢¢-Non-covered charges for accommodation.
50.	Fourth Accommodation					See Field 49.
	a. Accommodation Code	1	X	1	261	
	b. Number of Days	3	C3	2	262-263	
	c. Total Charges	7	C3	4	264-267	
	d. Non-Covered Charges	7	C3	4	268-271	
51.	Fifth Accommodation					See Field 49.
	a. Accommodation Code	1	X	1	272	
	b. Number of Days	3	C3	2	273-274	
	c. Total Charges	7	C3	4	275-278	
	d. Non-Covered Charges	7	C3	4	279-282	

	Information	Dec. Size	Usage 1/		Location	Description
52.	Blood Usage					Form SSA-1453 only, Item 19a.
	a. Code	1	X	1	283	Constant A.
	b. Pints Furnished	4	C3	3	284-286	000.0-one decimal position indicating if ½ pint included otherwise zeroes.
	c. Pints Replaced	4	C3	3	287-289	See Field 52.b.
	d. Pints Not Replaced	4	C3	3	290-292	See Field 52.b.
	e. Charge Per Pint	6	C3	4	293-296	$$$$¢¢-Zeroes if no charges for blood.
	f. Total Charges	7	C3	4	297-300	$$$$$¢¢-Charges for blood usage.
	g. Non-Covered Charges	7	C3	4	301-304	$$$$$¢¢-Non-covered charges for blood usage.
53.	First Service					
	a. Code	1	X	1	305	Constant H. Form SSA-1453 (Inpatient) Item 19H.
	b. Total Charges	7	C3	4	306-309	$$$$$¢¢-Charges for service.
	c. Non-Covered Charges	7	C3	4	310-313	$$$$$¢¢-Non-covered charges for service.
54.	Second Service					
	a. Code	1	X	1	314	Constant I. Form SSA-1453 (Inpatient) Item 19.I.
	b. Total Charges	7	C3	4	315-318	See Field 53.b.
	c. Non-Covered Charges	7	C3	4	319-322	See Field 53.c.
55.	Third Service					
	a. Code	1	X	1	323	Constant J. Form SSA-1453 (Inpatient) Item 19.J.
	b. Total Charges	7	C3	4	324-327	See Field 53.b.
	c. Non-Covered Charges	7	C3	4	328-331	See Field 53.c.
56.	Fourth Service					
	a. Code	1	X	1	332	Constant K. Form SSA-1453 (Inpatient, SNF). Item 19.K.
	b. Total Charges	7	C3	4	333-336	See Field 53.b.
	c. Non-Covered Charges	7	C3	4	337-340	See Field 53.c.

	Information	Dec. Size	Usage 1/		Location	Description
57.	Fifth Service					
	a. Code	1	X	1	341	Constant L. Form SSA-1453 (Inpatient, SNF). Item 19.L.
	b. Total Charges	7	C3	4	342-345	See Field 53.b.
	c. Non-Covered Charges	7	C3	4	346-349	See Field 53.c.
58.	Sixth Service					
	a. Code	1	X	1	350	Constant M. Form SSA-1453 (Inpatient, SNF). Item 19.M.
	b. Total Charges	7	C3	4	351-354	See Field 53.b.
	c. Non-Covered Charges	7	C3	4	355-358	See Field 53.c.
59.	Seventh Service					
	a. Code	1	X	1	359	Constant N. Form SSA-1453 (Inpatient, SNF). Item 19.N.
	b. Total Charges	7	C3	4	360-363	See Field 53.b.
	c. Non-Covered Charges	7	C3	4	364-367	See Field 53.c.
60.	Eighth Service					
	a. Code	1	X	1	368	Constant O. Form SSA-1453 (Inpatient, SNF). Item 19.O.
	b. Total Charges	7	C3	4	369-372	See Field 53.b.
	c. Non-Covered Charges	7	C3	4	373-376	See Field 53.c.
61.	Ninth Service					
	a. Code	1	X	1	377	Constant P. Form SSA-1453 (Inpatient, SNF). Item 19.P.
	b. Total Charges	7	C3	4	378-381	See Field 53.b.
	c. Non-Covered Charges	7	C3	4	382-385	See Field 53.c.

Information	Dec. Size	Usage 1/		Location	Description
62. Tenth Service					
a. Code	1	X	1	386	Constant Q. Form SSA-1453 (Inpatient, SNF). Item 19.Q.
b. Total Charges	7	C3	4	387-390	See Field 53.b.
c. Non-Covered Charges	7	C3	4	391-394	See Field 53.c.
63. Eleventh Service					
a. Code	1	X	1	395	Constant R. Form SSA-1453 (Inpatient, SNF). Item 19.R.
b. Total Charges	7	C3	4	396-399	See Field 53.b.
c. Non-Covered Charges	7	C3	4	400-403	See Field 53.c.
64. Twelfth Service					
a. Code	1	X	1	404	Constant S. Form SSA-1453 (Inpatient, SNF). Item 19.S.
b. Total Charges	7	C3	4	405-408	See Field 53.b.
c. Non-Covered Charges	7	C3	4	409-412	See Field 53.c.
65. Thirteenth Service					
a. Code	1	X	1	413	Constant T. Form SSA-1453 (Inpatient, SNF). Item 19.T.
b. Total Charges	7	C3	4	414-417	See Field 53.b.
c. Non-Covered Charges	7	C3	4	418-421	See Field 53.c.
66. Fourteenth Service					See Field 65.
a. Code	1	X	1	422	
b. Total Charges	7	C3	4	423-426	
c. Non-Covered Charges	7	C3	4	427-430	
67. Fifteenth Service					See Field 65.
a. Code	1	X	1	431	
b. Total Charges	7	C3	4	432-435	
c. Non-Covered Charges	7	C3	4	436-439	
68. Sixteenth Service					See Field 65.
a. Code	1	X	1	440	
b. Total Charges	7	C3	4	441-444	
c. Non-Covered Charges	7	C3	4	445-448	

	Information	Dec. Size	Usage 1/		Location	Description
69.	Seventeenth Service					See Field 65.
	a. Code	1	X	1	449	
	b. Total Charges	7	C3	4	450-453	
	c. Non-Covered Charges	7	C3	4	454-457	
70.	Totals					
	a. Total Charges	8	C3	5	458-462	$$$$$$¢¢-Charges for all accommodations and services. Form SSA-1453. Item 19.U.
	b. Non-Covered Charges	8	C3	5	463-467	$$$$$$¢¢-Non-covered charges for all accommodations and services. Form SSA-1453, Item 19.U.
71.	Inpatient Deductible	5	C3	3	468-470	$$$¢¢-Deductible to be paid by patient. Form SSA-1453, Item 19.V.
72.	Blood Deductible					
	a. Pints	3	C3	2	471-472	Form SSA-1453. Item 19.W. 00.0-one decimal position indicating if ½ pint included, otherwise zeroes.
	b. Charge Per Pint	6	C3	4	473-476	$$$$¢¢-Zeroes if no charges for blood.
	c. Blood Deductible	6	C3	4	477-480	$$$$¢¢-Charges for blood.
73.	Coinsurance					Form SSA-1453. Item 19.X.
	a. Days	3	C3	2	481-482	Zeroes filled, right justified.
	b. Rate	5	C3	3	483-485	$$$¢¢-Charge for each day of coinsurance.
	c. Amount	7	C3	4	486-489	$$$$$¢¢-Total amount for coinsurance.
74.	Total Deductions	8	C3	5	490-494	$$$$$$¢¢-Total for all deductions. Form SSA-1453. Item 19.Y.
75.	Date Forwarded	5	C3	3	495-497	YYDDD-Date bill received by the intermediary Form SSA-1453 Item 29.
76.	Date Guarantee of Payment Began	5	C3	3	498-500	YYDDD-Form SSA-1453. Item 21.

	Information	Dec. Size	Usage 1/		Location	Description
77.	Date UR Notice Received	5	C3	3	501-503	YYDDD-Form SSA-1453. Item 22.
78.	Date Active Care Ended	5	C3	3	504-506	YYDDD-Form SSA-1453. Item 23.
79.	Date Benefits Exhausted	5	C3	3	507-509	YYDDD-Form SSA-1453. Item 24.
80.	Patient Status					Form SSA-1453. Item 25.
	a. Code	1	X	1	510	A-Discharged B-Died C-Still patient
	b. Date of Discharge or Death	5	C3	3	511-513	YYDDD-Date present for code A or B. Zero if code C.
81.	Lifetime Reserve Days Used	2	C3	2	514-515	Zeroes filled, right justified. Form SSA-1453 (Inpatient). Item 26.
82.	Covered Days	3	C3	2	516-517	Total covered days for bill. Zeroes filled, right justified. Form SSA-1453, Item 28.
83.	PIP Per Diem Amount	8	C3	5	518-522	$$$$$$cc-Form SSA-1453 (PIP), Item 31.
84-86.	Administrative Fields	14	C3	9	523-531	Not used in statistical operations.
87.	Date Approved	5	C3	3	532-534	YYDDD-Date bill approved by the intermediary. Form SSA-1453, Item 35.
88.	Non-Covered Days	4	C3	3	535-537	Zeroes filled, right justified. Form SSA-1453, Item 27.
89.	State Code	2	X	2	538-539	State where the beneficiary resides.
90.	County Code	3	X	3	540-542	County where the beneficiary resides.
91.	Date of Birth	5	C3	3	543-545	YYDDD-Date of birth from master record.
92.	Sex	1	X	1	546	Sex code from master 0-Unknown 1-Male 2-Female
93.	Race	1	X	1	547	0-Unknown 1-White 2-Black 3-Other

	Information	Dec. Size	Usage 1/		Location	Description
94.	ZIP Code	5	X	5	548-552	Beneficiary ZIP Code from Master Identification Record.
95.	Blank	7	X	7	553-559	For future expansion.
96.	Record Mark	1	X	1	560	

1/ X-Decimal Field
C3-IBM Packed Decimal Field (Computational 3)

Exhibit B

Form Approved
Budget Bureau No.
No. 72 - R736

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

HOME HEALTH AGENCY REPORT AND BILLING
HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

1. PATIENT'S LAST NAME	FIRST NAME	MI	2. HEALTH INSURANCE CLAIM NUMBER

3. PATIENT'S ADDRESS *(Street number, City, State, Zip Code)*	4. DATE OF BIRTH	5. SEX
	__ __ / __ __ / __ __	☐ M ☐ F

6. HOME HEALTH AGENCY NAME AND ADDRESS	7. PROVIDER NO.	9. NAME AND ADDRESS OF ATTENDING PHYSICIAN
	8. MEDICAL RECORD NO.	

10. DATE CARE STARTED	11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES	12. VERIFIED DATES OF STAY IN ITEM 11 FROM	TO	13. DATE HOME HEALTH PLAN ESTABLISHED
__ __ / __ __ / __ __		__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __

14. PAYMENT SOURCE FOR CHARGES TO PATIENT

A. ☐ SELF OR FAMILY C. ☐ BLUE CROSS BLUE SHIELD E. ☐ PUBLIC AGENCY *(Give name)*

B. ☐ PRIVATE INSURANCE D. ☐ EMPLOYER OR UNION F. ☐ OTHER *(Explain)*

15. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.

SIGNATURE *(Patient or authorized representative) (Signature by mark must be witnessed)*	DATE

16. DIAGNOSES	EMPLOYMENT RELATED	*(If yes, give name and address of employer.)*	LEAVE BLANK
	A. ☐ YES B. ☐ NO		

17. STATEMENT COVERS PERIOD FROM	TO	18. DATE OF FIRST VISIT	DATE OF LAST VISIT	19. PATIENT	20. DATE APPLICABLE TO ITEM 19
__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	☐ DISCHARGED ☐ STILL RECEIVES SERVICES ☐ DIED ☐ VISITS EXHAUSTED	__ __ / __ __ / __ __

21. STATEMENT OF SERVICES RENDERED	POST - HOSPITAL PLAN		MEDICAL PLAN		22. POST - HOSPITAL PLAN	23. MEDICAL PLAN
PRIMARY PURPOSE OF VISIT	NO. VISITS	CHARGES	NO. VISITS	CHARGES	A. TOTAL CHARGES	A. VERIFIED DEDUCTIBLE
A. Skilled Nursing Care		$		$		
B. Physical Therapy					B. REIMBURSEMENT RATE	B. VERIFIED COINSURANCE
C. Speech Therapy						
D. Occupational Therapy						
E. Medical Social Services					C. REIMBURSEMENT AMT. A TIMES B	C. TOTAL CHARGES
F. Home Health Aide						
G. Other Visits *(Specify)*						O. REIMBURSEMENT RATE
H. Total No. of Units of Service						
I. Charge per unit of Service $						E. C TIMES O
J. TOTALS		$		$		F. E LESS A
K. Other *(Specify)*						G. REIMBURSEMENT AMT. 80% OF F
						H. REFUND TO PATIENT
L. TOTAL CHARGES		$		$		
M. AMOUNT PAID BY PATIENT				$		I. NET AMOUNT TO AGENCY, G LESS H

I certify that required physician's certification and recertifications are on file.

SIGNATURE OF HOME HEALTH AGENCY REPRESENTATIVE	DATE FORWARDED	APPROVED BY	DATE APPROVED
	__ __ / __ __ / __ __		__ __ / __ __ / __ __

FORM SSA - 1487 (3) (11-69)

Home Health Agency Bill Record

	Information	Dec. Size	Usage 1/		Location	Description
1.	Record Length	4	C3	3	1-3	Constant 380.
2.	Beneficiary Claim Number					
	a. CAN--Social Security Number	9	X	9	4-12	
	b. BIC--Type of Beneficiary	2	X	2	13-14	
3.	Record Identification Code	1	X	1	15	V-Home Health Part A W-Home Health Part B
4.	Statement Covers Period From Date	5	C3	3	16-18	YYDDD beginning date of stay Item 17.
5-8.	Administrative Fields	12	C3	10	19-28	Not used in statistical operations.
9.	Name					
	a. Surname	6	X	6	29-34	
	b. First Initial	1	X	1	35	
	c. Middle Initial	1	X	1	36	
10-11.	Administrative Fields	6	C3	4	37-40	Not used in statistical operations.
12.	Query Code	1	X	1	41	Code indicating status of bil 1-Interim bill 2-Visits exhausted 3-Final bill 5-Debit adjustment 0-Credit adjustment
13.	Administrative Fields	2	X	2	42-43	Not used in statistical operations.
14.	Receipt Date	5	C3	3	44-46	YYDDD-Date RIC was processed by the HI system.
15-19.	Administrative Fields	26	C3	22	47-68	Not used in statistical operations.
20.	Original, Corrected or X-Reference Number					
	a. Account Number	9	X	9	69-77	
	b. BIC	2	X	2	78-79	
21.	Administrative Fields	40	X	40	80-119	Not used in statistical operations.
22.	RTI Control Number	10	X	10	120-129	Control number for bill returned to the intermediary (signed plus).

	Information	Dec. Size	Usage 1/		Location	Description
23-24.	Administrative Fields	18	C3	17	130-146	Not used in statistical operations.
25.	Transaction Code	1	X	1	147	5-HH Agency
26-27.	Administrative Fields	2	X	2	148-149	Not used in statistical operations.
28.	Intermediary Number	5	X	5	150-154	Identification number of intermediary processing bill.
29.	Batch Number					
	a. Sequence Number	4	X	4	155-158	Control number assigned to batch by intermediary.
	b. Julian Date	4	X	4	159-162	YDDD-Julian date batched by the intermediary.
30.	Master Block Number					
	a. Julian Date	4	X	4	163-166	YDDD-Julian date blocked by SSA.
	b. Block Number	3	X	3	167-169	A three digit block number-indicates type of bills.
	c. Unit Number	1	X	1	170	A one-digit unit number.
31.	Sequence Number	2	X	2	171-172	Sequence number 01-55 assigned to bill (signed +) 77-Adjustment bill 88-Over 55 bills to a batch 99-Incomplete bill
32-36.	Administrative Fields	8	X	8	173-180	Not used in statistical operations.
37.	Medicare Status Code	2	X	2	181-182	ØØ-Unknown 10-Aged without CRD 11-Aged with CRD 20-Disabled without CRD 21-Disabled with CRD 31-CRD only
37a.	Filler	2	X	2	183-184	
38.	Provider Identification Number	6	X	6	185-190	Item 7. Provider number on bill.
39.	Statement Covers Period Through Date	5	C3	3	191-193	Item 17. YYDDD-Ending date of service.
40.	Reimbursement Amount	8	C3	5	194-198	$$$$$$çç-Item 22.G, if plan P. Item 23.G, if plan M.

	Information	Dec. Size	Usage 1/		Location	Description
41.	Date Care Started	5	C3	3	199-201	Item 10. YYDDD-Beginning date of care.
42.	Verified Dates of Stay					
	a. From Date	5	C3	3	202-204	Item 12. YYDDD-Start date of prior stay.
	b. To Date	5	C3	3	205-207	YYDDD-Ending date of prior stay.
43.	Date Plan Established	5	C3	3	208-210	Item 13. YYDDD-Beginning date of Home Health Plan.
44.	Diagnosis Code	5	X	5	211-215	Item 16. Present on sample home health bills. Blank if not present.
45.	Not Used	4	X	4	216-219	ⱥⱥⱥⱥ.
46.	Plan Code	1	X	1	220	Indicates type of bill P-Post hospital plan (Part A) M-Medical plan (Part B)
47.	First Service					
	a. Code A	1	X	1	221	Item 21.A. Code for service.
	b. Visits	3	C3	2	222-223	Number of visits.
	c. Charges	7	C3	4	224-227	$$$$$¢¢-Charges for service code.
48.	Second Service					Item 21.B. See field 47.
	a. Code B	1	X	1	228	
	b. Visits	3	C3	2	229-230	
	c. Charges	7	C3	4	231-234	
49.	Third Service					Item 21.C. See field 47.
	a. Code C	1	X	1	235	
	b. Visits	3	C3	2	236-237	
	c. Charges	7	C3	4	238-241	
50.	Fourth Service					Item 21.D. See field 47.
	a. Code D	1	X	1	242	
	b. Visits	3	C3	2	243-244	
	c. Charges	7	C3	4	245-248	
51.	Fifth Service					Item 21.E. See field 47.
	a. Code E	1	X	1	249	
	b. Visits	3	C3	2	250-251	
	c. Charges	7	C3	4	252-255	

	Information	Dec. Size	Usage 1/		Location	Description
52.	Sixth Service					Item 21.F. See field 47.
	a. Code F	1	X	1	256	
	b. Visits	3	C3	2	257-258	
	c. Charges	7	C3	4	259-262	
53.	Seventh Service					Item 21.G. See field 47.
	a. Code G	1	X	1	263	
	b. Visits	3	C3	2	264-265	
	c. Charges	7	C3	4	266-269	
54.	Eighth Service					Item 21.G. See field 47.
	a. Code G	1	X	1	270	
	b. Visits	3	C3	2	271-272	
	c. Charges	7	C3	4	273-276	
55.	Total Number of Units of Service					Item 21.H.
	a. Code H	1	X	1	277	Constant H. Blank if entry in visits and charges in A through G. If no entry or only visits in A through G, must have entry in H and I or K.
	b. Number of Units	3	C3	2	278-279	Number of units of service. Zeroes filled, right justified.
56.	Charge Per Unit of Service					Item 21.I.
	a. Code I	1	X	1	280	Constant I.
	b. Charge Per Unit	5	C3	3	281-283	$$$¢¢-Charge for each unit of service.
57.	Totals (Item J)					Item 21.J.
	a. Total Visits	3	C3	2	284-285	Total number of visits for all service A-I.
	b. Charges	7	C3	4	286-289	$$$$$¢¢-Total charges for all services A-I.
58.	Other Services (Item K)					Item 21.K.
	a. Code K	1	X	1	290	Constant K.
	b. Charges	7	C3	4	291-294	$$$$$¢¢-Charges for service
59.	Other Services (Item K)					See field 58.
	a. Code K	1	X	1	295	
	b. Charges	7	C3	4	296-299	
60.	Other Services (Item K)					See field 58.
	a. Code K	1	X	1	300	
	b. Charges	7	C3	4	301-304	
61.	Other Services (Item K)					See field 58.
	a. Code K	1	X	1	305	
	b. Charges	7	C3	4	306-309	

	Information	Dec. Size	Usage	1/	Location	Description
62.	Total Charges (Item L)	7	C3	4	310-313	Item 21.L. $$$$$¢¢-Total charges for all services A-K.
63.	Amount Paid by Patient	7	C3	4	314-317	Item 21.M. $$$$$¢¢-Amount paid by patient.
64.	Date Forwarded	5	C3	3	318-320	YYDDD-Date bill received by intermediary.
65.	Patient Status a. Code	1	X	1	321	Item 19. Status of patient. A-Discharged B-Died C-Still receives services D-Visits exhausted
	b. Date	5	C3	3	322-324	Item 20. YYDDD-Date applicable to patient status.
66.	Total Charges	7	C3	4	325-328	Item 22.A. $$$$$¢¢-Total charges for all Plan P services.
67.	Reimbursement Rate	4	C3	3	329-331	Item 22.B. XXX.X-Percentage rate with one position for decimals for Plan P.
68.	Verified Deductible	5	C3	3	332-334	Item 23.A. $$$¢¢-Plan M.
69.	Verified Coinsurance	6	C3	4	335-338	Item 23.B. $$$$¢¢-Plan M.
70.	Total Charges	7	C3	4	339-342	Item 23.C. $$$$$¢¢-Total charges for all Plan M services.
71.	Reimbursement Rate	4	C3	3	343-345	Item 23.D. XXX.X-Percentage rate with one position for decimals for Plan M.
72.	Item 23.E	7	C3	4	346-349	Item 23.E. $$$$$¢¢-Total charges (23.C) times reimbursement rate (23.D) for Plan M.
73.	Item 23.F	7	C3	4	350-353	Item 23.F. $$$$$¢¢-Total from 23.E minus verified deductible (23.A) for Plan M.
74.	Refund to Patient	7	C3	4	354-357	Item 23.H. $$$$$¢¢-Refund to patient for Plan M.

	Information	Dec. Size	Usage 1/		Location	Description
75.	Net Amount to Agency	7	C3	4	358-361	Item 23.I. $$$$$¢¢-Reimbursement amount (23.G) minus refund to patient (23.H) for Plan M.
76.	Date Approved	5	C3	3	362-364	YYDDD-Date bill approved by the intermediary.
77.	State Code	2	X	2	365-366	State where the beneficiary resides.
78.	County Code	3	X	3	367-369	County where the beneficiary resides.
79.	Date of Birth	5	C3	3	370-372	YYDDD-Date of birth from master record.
80.	Sex	1	X	1	373	Sex code from master 0-Unknown 1-Male 2-Female
81.	Race	1	X	1	374	0-Unknown 1-White 2-Black 3-Other
82.	ZIP Code	5	X	5	375-379	Beneficiary ZIP Code from RIC A master identification record.
83.	Record Mark	1	X	1	380	

1/ X-Decimal Field
C3-IBM Packed Decimal Field (Computational 3)

Exhibit C

PROVIDER BILLING FOR MEDICAL AND OTHER HEALTH SERVICES

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

Form Approved
OMB No. 72-R0738

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

1. Patient's last name	First name	MI	2. Health insurance claim number
3. Patient's address (Street number, City, State, ZIP Code)			4. Date of birth / 5. Sex ☐ M ☐ F
6. Provider name and address (City and State)	7. Provider number		9. Type of service A. ☐ Inpatient C. ☐ Other (Specify) B. ☐ Outpatient
	8. Medical record number		

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to them upon their request, complete items 10 and 11.

10. Insuring organization and/or State agency name and address	11. Policy and/or medical assistance number

12. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

☐ Contained in provider's record	Signature (Patient or authorized representative) (Signature by mark must be witnessed)	Date

13. Nature of illness or injury ☐ Check here if illness or injury was connected with employment

Do not use this space

14. Surgical procedures

15. Statement of services	Covered Charges
A. Clinic visit ( )	
B. Emergency room ( )	
C. Laboratory	
D. Radiology	
E. Pharmacy	
F. Blood	
G. Ambulance	
H. Physical therapy	
I. Other (Specify)	
J. TOTAL	

16. Statement Covers Period — First service / Last service

17. Blood Information

A. Pints furnished	B. Pints replaced	C. Pints Not Replaced	D. Charge per pint	E. Patient paid for deductible

18. Professional component (hospital inpatients) A. Pathology B. Radiology

19. Other professional component

20. Date benefits exhausted or HH plan terminated

21. Patient paid (Excluding 17E)

22. I certify that the required physician's certification is on file.

23. Date received

FOR INTERMEDIARY USE ONLY

24. Verified Patient Liability

A. Blood deductible	B. Cash deductible	C. Coinsurance

25. Payment Distribution

Provider	Patient

26. Date approved

Remarks:

FORM SSA-1483 1-73

Department of Health, Education, and Welfare
Social Security Administration

Outpatient Bill Record

	Information	Dec. Size	Usage 1/		Location	Description
1.	Record Length	4	C3	3	1-3	Constant 365.
2.	Beneficiary Claim No.					
	a. CAN-Social Security Number	9	X	9	4-12	
	b. BIC-Type of Beneficiary	2	X	2	13-14	
3.	Record Identification Code	1	X	1	15	W-Outpatient Part B
4.	Statement Covers Period from Date	5	C3	3	16-18	YYDDD-Beginning date of stay. Item 16.
5-8.	Administrative Fields	12	C3	10	19-28	Not used in statistical operations.
9.	Name					
	a. Surname	6	X	6	29-34	
	b. First Initial	1	X	1	35	
	c. Second Initial	1	X	1	36	
10-11.	Administrative Fields	6	C3	4	37-40	Not used in statistical operations.
12.	Query Code	1	X	1	41	Code indicating status of bill 3-Final bill 5-Debit adjustment 0-Credit adjustment
13-19.	Administrative Fields	33	C3	27	42-68	Not used in statistical operations.
20.	Original, Corrected or Cross-Reference Number					
	a. Account Number	9	X	9	69-77	
	b. BIC	2	X	2	78-79	
21.	a. Administrative Fields	3	X	3	80-82	Not used in statistical operations.
	b. Type of Service	1	X	1	83	1-Inpatient 2-Outpatient 3-Other
	c. Administrative Fields	36	X	36	84-119	Not used in statistical operations.
22.	RTI Control Number	10	X	10	120-129	Control number for bill returned to the intermediary signed plus.

	Information	Dec. Size	Usage 1/		Location	Description
23-27.	Administrative Fields	21	C3	20	130-149	Not used in statistical operations.
28.	Intermediary Number	5	X	5	150-154	Identification number of intermediary processing bill.
29.	Batch Number					
	a. Sequence Number	4	X	4	155-158	Control number assigned to batch by intermediary.
	b. Julian Date	4	X	4	159-162	YDDD-Julian date batched by the intermediary.
30.	Master Block Number					
	a. Julian Date	4	X	4	163-166	YDDD-Julain date blocked by SSA.
	b. Block Number	3	X	3	167-169	A three digit block number--indicates type of bills.
	c. Unit Number	1	X	1	170	A one digit unit number.
31.	Sequence Number	2	X	2	171-172	Sequence number 01-55 assigned to bill (signed +) 77-Adjustment bill 88-Over 55 bills to a batch 99-Incomplete bill
32-36.	Administrative Fields	8	X	8	173-180	Not used in statistical operations.
37.	Medicare Status Code	2	X	2	181-182	⁂-Unknown 10-Aged without CRD 11-Aged with CRD 20-Disabled without CRD 21-Disabled with CRD 31-CRD only
37a.	Filler	2	X	2	183-184	
38.	Provider Identification	6	X	6	185-190	Item 7 Provider Number on bill.
39.	Statement Covers Period Last Service	5	C3	3	191-193	YYDDD-Date of last service.
40.	Payment Distribution (Reimbursement Amount)	8	C3	5	194-198	$$$$$$¢¢-Item 25. Sum of amounts shown in payment distribution (provider amount (337-340) plus patient amount (341-344)).
41.	Nature of Illness Code	5	X	5	199-203	Item 13-Code present on 5% of bills. Blank if not a sample bill.

	Information	Dec. Size	Usage 1/		Location	Description
42.	Surgical Date	5	C3	3	204-206	YYDDD-Item 14. Date for surgical procedures performed. If entry in surgical procedures but no date, zeroes are used. Blank if no entry.
43.	Surgical Code	5	X	5	207-211	Item 14. Blank if no code shown.
44.	First Service					Item 15.A. (Clinic Visit)
	a. Code A	1	X	1	212	Constant A.
	b. Visits	3	C3	2	213-214	Number of visits. Zero filled, right justified.
	c. Covered Charges	7	C3	4	215-218	$$$$$¢¢-Charges for services.
45.	Second Service					Item 15.B. (Emergency Room)
	a. Code B	1	X	1	219	Constant B.
	b. Visits	3	C3	2	220-221	See field 44b.
	c. Covered Charges	7	C3	4	222-225	See field 44c.
46.	Third Service					Item 15.C. (Laboratory)
	a. Code C	1	X	1	226	Constant C.
	b. Covered Charges	7	C3	4	227-230	$$$$$¢¢-Charges for services.
47.	Fourth Service					Item 15.D. (Radiology)
	a. Code D	1	X	1	231	Constant D.
	b. Covered Charges	7	C3	4	232-235	$$$$$¢¢-Charges for services.
48.	Fifth Service					Item 15.E. (Pharmacy)
	a. Code E	1	X	1	236	Constant E.
	b. Covered Charges	7	C3	4	237-240	$$$$$¢¢-Charges for services.
49.	Sixth Service					Item 15.F. (Blood)
	a. Code F	1	X	1	241	Constant F.
	b. Covered Charges	7	C3	4	242-245	$$$$$¢¢-Charges for services.
50.	Seventh Service					Item 15.G. (Ambulance)
	a. Code G	1	X	1	246	Constant G.
	b. Covered Charges	7	C3	4	247-250	$$$$$¢¢-Charges for services.
51.	Eighth Service					Item 15.H. (Physical Therapy)
	a. Code H	1	X	1	251	Constant H.
	b. Covered Charges	7	C3	4	252-255	$$$$$¢¢-Charges for services.
52.	Ninth Service					Item 15.I. (Other Service Services)
	a. Code I	1	X	1	256	Constant I.
	b. Covered Charges	7	C3	4	257-260	$$$$$¢¢-Charges for services.
53.	Tenth Service					See field 52.
	a. Code I	1	X	1	261	
	b. Covered Charges	7	C3	4	262-265	

	Information	Dec. Size	Usage	1/	Location	Description
54.	Eleventh Service					See field 52.
	a. Code I	1	X	1	266	
	b. Covered Charges	7	C3	4	267-270	
55.	Twelfth Service					See field 52.
	a. Code I	1	X	1	271	
	b. Covered Charges	7	C3	4	272-275	
56.	Thirteenth Service					See field 52.
	a. Code I	1	X	1	276	
	b. Covered Charges	7	C3	4	277-280	
57.	Fourteenth Service					See field 52.
	a. Code I	1	X	1	281	
	b. Covered Charges	7	C3	4	282-285	
58.	Blood Usage					Item 17.
	a. Pints Furnished	3	C3	2	286-287	Item 17.A. 00.0-One decimal position indicating if ½ pint included otherwise zeroes.
	b. Pints Replaced	3	C3	2	288-289	Item 17.B. See field 58a.
	c. Pints Not Replaced	3	C3	2	290-291	Item 17.C. See field 58a.
	d. Charge Per Pint	6	C3	4	292-295	Item 17.D. $$$$¢¢-Zeroes if no charges for blood.
	e. Patient Paid for Deductible	6	C3	4	296-299	Item 17.E. $$$$¢¢-Charges to patient for blood not replaced.
59.	Professional Components					$$$$¢¢-Amount for hospital inpatients or other professional components.
	a. Pathology	6	C3	4	300-303	Item 18.A.
	b. Radiology	6	C3	4	304-307	Item 18.B.
	c. Other	6	C3	4	308-311	Item 19.
60.	Date Benefits Exhausted or HH Plan Terminated	5	C3	3	312-314	YYDDD-Item 20. Blank if no date shown.
61.	Patient Paid	6	C3	4	315-318	$$$$¢¢-Item 21. Amount paid by patient (less Item 17.E).
62.	Date Forwarded	5	C3	3	319-321	YYDDD-Item 23. Date bill received by intermediary.
63.	Verified Patient Liability					Amount for patient liability.
	a. Blood Deductible	6	C3	4	322-325	$$$$¢¢-Item 24.A.
	b. Cash Deductible	5	C3	3	326-328	$$$¢¢-Item 24.B.
	c. Coinsurance	6	C3	4	329-332	$$$$¢¢-Item 24.C.
64.	Total Charges	7	C3	4	333-336	$$$$¢¢-Item 15.J. Total charges for all services in Item 15.

	Information	Size	Usage 1/	Dec.	Location	Description
65.	Payment Distribution					
	a. Provider	7	C3	4	337-340	$$$$$¢¢-Amount of payment to provider.
	b. Patient	7	C3	4	341-344	$$$$$¢¢-Amount of payment to patient.
66.	Date Approved	5	C3	3	345-347	YYDDD-Item 26. Date bill approved by the intermediary.
67.	State Code	2	X	2	348-349	State where the beneficiary resides.
68.	County Code	3	X	3	350-352	County where the beneficiary resides.
69.	Date of Birth	5	C3	3	353-355	Date of birth from master record.
70.	Sex	1	X	1	356	Sex code from master 0-Unknown 1-Male 2-Female
71.	Race	1	X	1	357	0-Unknown 1-White 2-Black 3-Other
72.	ZIP Code	5	X	5	358-362	Beneficiary ZIP Code.
73.	Blank	2	X	2	363-364	
74.	Record Mark	1	X	1	365	

1/ X-Decimal Field
C3-IBM Packed Decimal Field (Computational 3)

01/14/77

Exhibit D

Index of Medicare Bill Data Tabulations

Table Number	Type of Records	Information	Enrollees	Period	Frequency
Control Tables					
PROUD (from BDP)	All Part A and Part B Bills	Bills, amount reimbursed, type of bill	All	Month processed	Monthly
WHIM	All Part A and Part B Bills	Bills by Medicare Status code, type of bill	All	Week processed	Monthly
Paid Claims	All Part A and Part B Bills	Bills, amount reimbursed, type of bill	All	Month processed	Monthly
Actuariel	All Part A and Part B Bills	Bills, amount reimbursed, type of bill	All, aged, disabled	Month processed	Monthly
Hospital Discharges	All inpatient hospital stay records -- 20% Sample	Discharges, total days, total charges, covered days, covered charges, amount reimbursed, age, sex, race, surgery, alive, dead	Aged, disabled	Year of discherge	Semi-annually
SNF Discharges	All inpatient SNF stay records for discharges	Discharges, covered days, covered charges, amount reimbursed, total days, age, sex, race, alive, dead	Aged, disabled	Year of discharge	Semi-annually
Paid Claims					
A1	Bills with Part A reimbursement	Bills amount reimbursed, type of bill	All, aged, disabled, ESRD	Month claim approved	Monthly
A2	Inpatient hospital bills with reimbursement	Bills, total days, total charges, type of hospital	All, aged, disabled, ESRD	Month claim approved	Monthly
A3	Inpatient hospital bills with reimbursement	Discherge bills with reimbursement	All	Month processed, month discharged	Quarterly

Table Number	Type of Records	Information	Enrollees	Period	Frequency
Paid Claims con't					
A4	Inpatient hospital stay records with reimbursement	Discharges, total days	All	Month of discharge	Semi-annually
A5	Inpatient hospital stay records with reimbursement	Discharges, covered days, covered charges	All	Month of discharge	Semi-annually
A6	Inpatient hospital stay records with reimbursement	Discharges, total days, total charges	All	Month of discharge	Semi-annually
A7	Inpatient SNF stay records with reimbursement for discharges	Discharges, total days	All	Month of discharge	Semi-annually
A8	Inpatient SNF stay records with reimbursement "benefits exhausted, discharge status unknown"	Stays, total days	All	Month benefits exhausted	Semi-annually
A9	All inpatient short-stay hospital bills with a date of discharge	Discharges, total days, State and PSRO of hospital	All, aged, disabled	Calendar quarter of discharge	Quarterly
A10	All inpatient short-stay hospital bills with a date of discharge	Discharges, total days, State and PSRO of hospital, each hospital	All, aged, disabled	Calendar quarter of discharge	Quarterly
B1	Bills with Part B reimbursement	Bills, total charges, amount reimbursed, type of bill	All, aged, disabled, ESRD	Month processed	Monthly
B2	Bills with Part B reimbursement	Bills, total charges, amount reimbursed, type of bill	All, aged, disabled, ESRD	Month processed	Monthly
Utilization by Intermediary and Carrier					
1	Bills with Part A and Part B reimbursement	Bills, amount reimbursed, type of bill, intermediary	All	Month claim approved	Quarterly
2	Payment Records	Payment Records, amount reimbursed, carrier	All	Month processed	Quarterly

Table Number	Type of Records	Information	Enrollees	Period	Frequency
Current Utilization					
AA1	Bills with Part A reimbursement	Bills, amount reimbursed, type of bill	All, aged, disabled	Month claim approved	Monthly
AA1A (State)	Bills with Part A reimbursement	Bills, amount reimbursed, type of bill	All, aged, disabled	Month claim approved	Semi-annually
AA2	Bills with Part A reimbursement	Bills, amount reimbursed, type of bill	All, aged, disabled	Month expense incurred	Monthly
AA2A (State)	Bills with Part A reimbursement	Bills, amount reimbursed, type of bill	All, aged, disabled	Month expense incurred	Semi-annually
AA3	All inpatient hospital bills	Bills, total days, total charges, covered days, covered charges, amount reimbursed, type of hospital	All, aged, disabled	Month claim approved	Monthly
AA3A (State)	All inpatient hoepital bills	Bills, total days, total charges, covered days, covered charges, amount reimbursed, type of hospital	All, aged, disabled	Month claim approved	Semi-annually
AA4	All inpatient hospital bills	Bills, total days, total charges, covered days, covered charges, amount reimbursed, type of hospital	All, aged, disabled	Month expense incurred	Monthly
AA4A (State)	All inpatient hospital bills	Bills, total days, total charges, covered days, covered charges, amount reimbursed, type of hospital	All, aged, disabled	Month expense incurred	Semi-annually

Table Number	Type of Records	Information	Enrollees	Period	Frequency
Current Utilization con't					
AA4B (State)	All inpatient hospital bills	Bills, total days, total charges covered days, covered charges, amount reimbursed, type of hospital	All, aged, disabled	Month expense incurred	Quarterly
AA5	Short-stay inpatient hospital stay records with reimbursement	Discharges, total days, total charges, covered days, amount reimbursed	All, aged, disabled	Month of discharge	Quarterly
AA5A (State)	Short-stay inpatient hospital stay records with reimbursement	Discharges, total days, total charges, covered days, amount reimbursed	All, aged, disabled	Month of discharge	Quarterly
AA6	All short-stay inpatient hospital stay records	Discharges, total days, total charges, covered days, amount reimbursed	All, aged, disabled	Quarter of discharge	Quarterly
AA7	All SNF bills	Bills, covered days, covered charges, amount reimbursed	All, aged, disabled	Month claim approved	Monthly
AA7A (State)	All SNF bills	Bills, covered days, covered charges, amount reimbursed	All, aged disabled	Month claim approved	Semi-annually
AA8	All SNF bills	Bills, covered days, covered charges, amount reimbursed	All, aged, disabled	Month expense incurred	Monthly
AA8A (State)	All SNF bills	Bills, covered days, covered charges, amount reimbursed	All, aged, disabled	Month expense incurred	Semi-annually
AA8B (State)	All SNF bills	Bills, covered days, covered charges, amount reimbursed	All, aged, disabled	Month expense incurred	Quarterly
AA9	All SNF stay records for discharges	Stays, covered days, amount reimbursed	All, aged, disabled	Quarter of discharge	Quarterly
AA10	All SNF stay records for "benefits exhausted, discharge status unknown"	Stays, covered days, amount reimbursed	All, aged, disabled	Quarter benefits exhausted	Quarterly

Table Number	Type of Records	Information	Enrollees	Period	Frequency
Current Utilization con't					
AA11	All Part A and Part B HHA bills	Bills, services, visits, covered charges, amount raimbursad	All, aged, disabled	Month claim approved	Monthly
AA11A (State)	All Part A and Part B HHA bills	Bills, services, visits, covered charges, amount raimbursed	All, aged, disabled	Month claim approved	Semi-annually
AA12	All Part A and Part B HHA bills	Bills, services, visits, covered charges, amount reimbursad	All, aged, disabled	Month expense incurred	Monthly
AA12A (State)	All Part A and Part B HHA bills	Bills, services, visits, covered charges, amount reimbursed	All, agad, disabled	Month expense incurred	Semi-annually
AA12B (State)	All Part A and Part B HHA bills	Bills, services, visits, covarad chargas, amount reimbursed	All, aged, disabled	Month expensa incurred	Quarterly
BB1	Bills with Part B raimbursament	Bills, amount reimbursed, typa of bill	All, aged, disabled	Month claim approved	Monthly
BB1A (Stata)	Bills with Part B raimbursement	Bills, amount raimbursed, typa of bill	All, aged, disabled	Month claim approved	Semi-annually
BB2	Bills with Part B reimbursement	Bills, amount reimbursed, typa of bill	All, aged, disabled	Month expense incurred	Monthly
BB2A (Stata)	Bills with Part B raimbursement	Bills, amount raimbursed, typa of bill	All, aged, disabled	Month expense incurred	Semi-annually
BB3	Bills with Part B raimbursament	Bills, covered charges, amount reimbursad, typa of bill	All, aged, disabled	Month processad	Monthly

Table Number	Type of Records	Information	Enrollees	Period	Frequency
Current Utilization con't					
BB4	Bills with Part B raimbursement	Bills, covered charges, amount reimbursed, type of bill, physician services	All, aged, disabled	Month claim approved	Monthly
BB5	Bills with Part B raimbursement	Bills, covered charges, amount reimbursed, type of bill, physician services	All, aged, disabled	Month expense incurred	Monthly
BB6	All Payment Records	Payment Records, reasonabla charges, amount reimbursed, carrier	All	Month claim approved	Semi-annually
BB7	All Payment Records	Payment Records, reasonable charges, amount raimbursed, carrier	All	Month claim approved	Semi-annually
Annual Data					
Provider Payment Report (PPR)	All Part A and Part B Institutional Bills	Bills, amount reimbursed, type of bill, provider	All	Year claim approved	Annually - 6 months after end of year
State and County Reimbursement (SCR)	All Part A and Part B bills with reimbursement	Persons enrolled and amount reimbursed, State, County, SMSA	All, aged, disabled	Year claim approved	Annually - 6 months after end of year
Person Summary Tabulations	All Part A and Part B bills with reimbursement	Persons enrolled, amount reimbursed, type of bill, State, age, sex, race	Aged, disabled	Year expense incurred	Annually - 18 months after end of year
Short-stay Hospital Tabulations (SSH)	All short-stay inpatiant hospital stay racords	Discharges, total days and charges, covered days and charges, amount reimbursed, provider characteristics, State, age, sex, race, discharge status, surgery	Aged, disabled	Year of diacharge	Annually - 2 years after end of year

Exhibit E

Medicare Sample Sizes for Diagnosis and Procedure Coding

Type of Medicare Benefit	Billing Form	Sample Size	Information Coded
Inpatient Hospital	SSA-1453	20%	Primary discharge diagnosis and primary surgical procedure (if any)
Skilled Nursing Facility (SNF)	SSA-1453	100%	Primary admitting diagnosis
Medical and Other Health Services	SSA-1483	5% (for services 1971 or later) 20% (July 1968 thru 1970) 40% (July 1966 - June 1968)	Primary nature of illness and primary surgical procedure (if any)
Home Health Agency - Part A & Part B	SSA-1487	40%	Primary diagnosis

Diagnostic coding for services thru 1970 --ICDA 7

Diagnostic coding for services after 1970 -- ICDA 8

Surgical procedure coding for all years -- CPT

Exhibit F

AMCS Coding Record

	Field Name	Number of Positions	Positions BEG	Positions END	Contents
1.	HI Claim Number	11	01	11	
2.	Provider Number	6	12	17	
3.	From Date	5	18	22	Format YYDDD
4.	Intermediary Number	5	23	27	
5.	Batch Number	4	28	31	
6.	Batch Date	4	32	35	Format YDDD
7.	Sequence Within Batch	2	36	37	
8.	Type of Facility	1	38	38	Ø=Payment 0=Christian Science 1=Psychiatric 2=Tubercular 3=General Care 4=ECF (SNF) 5=HHA Part A 6=Outpatient 7=HHA Part B
9.	Bill Type	1	39	39	0=Payment 9=Non-Payment
10.	Payment Status	1	40	40	
11.	Narrative Indicator	1	41	41	0=No narrative 1=Diagnostic 2=Surgical 3=Diagnostic Surgical
12.	Run Date	5	42	46	YYDDD - Julian Date
13.	ICDA Code (Diag)	4	47	50	
14.	Additional Indicator (Diag)	1	51	51	0=No additional diagnostic terms 1=Additional diagnostic terms 9=Unknown
15.	Serial (Diag)	4	52	55	
16.	Term Length (Diag)	2	56	57	

	Field Name	Number of Positions	Positions BEG	Positions END	Contents
17.	Match Indicator	1	58	58	0=Actual Code 1=Proposed Code 2=Proposed Code with 100% dictionary match 3=Proposed Code with less than 100% dictionary match
18.	Match Count (Diag)	2	59	60	Number of characters that matched dictionary term
19.	Narrative (Diag)	45	61	105	Occurrence determined by narrative indicator
20.	Filler	23	106	128	
21.	ICDA Code (Surg)	4	129	132	
22.	Additional Indicator (Surg)	1	133	133	0=No additional surgical terms 1=Additional surgical terms 9=Unknown
23.	Serial (Surg)	4	134	137	
24.	Term Length (Surg)	2	138	139	
25.	Match Indicator (Surg)	1	140	140	0=Actual code 1=Proposed code 2=Proposed code with 100% dictionary match 3=Proposed code with less than 100% dictionary term
26.	Match Count (Surg)	2	141	142	Number of characters that matched dictionary term
27.	Narrative (Surg)	45	143	187	Occurrence determined by narrative indicator
28.	Filler	17	188	204	
29.	Date of Surgery	5	205	209	Format YYDDD, begins 04/78
30.	Filler	2	210	211	
31.	Reference Key	10	212	221	5 position Julian date 5 position Sequence number

	Field Name	Number of Positions	Positions BEG	Positions END	Contents
32.	Active Code	1	222	222	1=Diagnistoc only 2=Surgical only 3=Duplicate record; diagnostic skeleton 4=Duplicate record; surgical skeleton
33.	Filler	1	223	223	
34.	Diag.-Surg. Ind.	1	224	224	D=Diagnostic; S=Surgical

V. Part B Payment Records

Introduction

Part B Supplementary Medical Insurance (SMI) benefits are payable for physician's services, home health service visits, outpatient hospital services and other medical services and supplies. Medical insurance benefits for home health services and outpatient hospital services where the bills are processed by a Part A Intermediary are covered in other chapters. This chapter relates to physician services and other medical services and suppliers where the requests for payment are processed by Part B carriers. Payments are generally made on a charge basis and are generally subject to both an annual deductible amount and a coinsurance amount. Specific medical services not subject to any deductible or coinsurance amounts are detailed in the "Preparation of the Payment Record" portion of this chapter. Payments for services can be made directly to a physician (or other supplier of medical services) if they accept assignment or to the beneficiary if assignment is not accepted by the physician or supplier. Bascially three forms are used to request payment. (See Exhibits C-E for copies of these forms.)

1. The Form SSA-1490 is the basic Part B claim form used by either the patient or physician (supplier) to claim reimbursement.

2. The Form SSA-1554 is used by hospitals to bill for hospital based physician services.

3. The Form SSA-1556 is used by Group Practice Prepayment Plans dealing through a carrier, where reimbursement is based on reasonable charges.

HCFA, which has the basic responsibility for administering the SMI program enters into agreements with public or private organizations, which serve as carriers to help administer the medical insurance benefit claims process. These contractor organizations, using SSA coverage and claims processing guidelines, determine which services are covered, determine amounts payable and make payment to providers and beneficiaries. They also communicate utilization and benefit information to SSA.

Carriers prepare and send to SSA a payment record for every bill for which reimbursement is made under the Supplementary Medical Insurance Program. The payment record has very important administrative and statistical uses. The primary purpose of the payment record is to enable HCFA to equate the amount of reimbursement shown on the payment record to the amount reported and disbursed on the Monthly Intermediary Financial Reports (Forms SSA-1522) submitted by the carriers. Other areas in which payment record data are used extensively are:

a. To provide current information on supplementary medical insurance benefit payments and to make possible the preparation of a variety of operating statistics.

b. To provide information to assist in the conduct of administrative and fiscal audits of carrier operations.

c. To draw samples for special ad hoc studies focusing on specific groups of doctors, costly procedures, or on specific types of services.

Because of their importance, all carriers prepare payment records uniformly in accordance with the instructions contained in the Medicare Carrier's Manual and transmit them promptly to the Social Security Administration.

SSA's Bureau of Data Processing (BDP) handles the automated processing of payment records and has the responsibility to determine the appropriateness of payments made by carriers based on an EDP analysis of the data contained in the payment records and the related master record data maintained in SSA. Entitlement to benefits during the period in which expenses were incurred, deductible satisfied, proper computation of the reimbursable amount, etc., are monitored by SSA in the data edit/validation processes. Inconsistencies detected are returned to the carriers for investigation, correction, and resubmission. A "suspense" file of all rejected records is maintained by BDP to ensure their return. As these records are corrected and returned, they are deleted from the suspense file and processed in the utilization routines.

Preparation of the Payment Record

A payment record is prepared by a carrier after the amount of reimbursement on an individual bill has been determined and payment is being made. A "bill" is defined as a request for payment from a beneficiary accompanied by one or more itemized statements from a single physician or single supplier. A payment records is submitted for every bill for which reimbursement is made. No payment record is prepared for any bill for which no reimbursement is made. Situations will arise--e.g., overpayments or incomplete information--where carriers determine that the amount reimbursed for a specific bill is incorrect and needs to be adjusted. In those instances, a corrected payment record is submitted.

The number of bills on a request for payment is determined by the number of different beneficiary-physician (or supplier) relationships represented. For example, a request for payment accompanied by itemized statements from only one physician or supplier constitutes only one bill, regardless of the number of occasions of service. A request for payment accompanied by itemized statements from two physicians or suppliers constitutes two bills, etc.

A definition of a payment record is generally the same as that of a bill. A reimbursement request for payment from a beneficiary accompanied by one or more itemized statements from the same physician requires preparation of only one payment record. On the other hand, if a beneficiary had accumulated and submitted itemized statements from two physicians for medical treatment and from an orthotist for fitting and purchase of an artificial leg and reimbursement was made for the services of all three, the carrier prepares three payment records--one for each physician's services and one for the orthotist's services.

Separate payment records are prepared when a bill is submitted for services rendered in different calendar years in each of which the deductible had been met and reimbursement made.

Separate payment records are also prepared for bills submitted covering specific services requiring special payment procedures designated by Amendments to the Medicare Law. These services include:

1. Hospital - Based Radiologists and Pathologists

   Services of these types of physicians rendered after March 31, 1968, to hospital inpatients in a qualified hospital are reimbursed at 100 percent

of reasonable charges with no deductible or coinsurance applied. Therefore, a payment record is prepared for each radiologist or pathologist identified on Form SSA-1554. If the Form SSA-1554 did not identify the individual physician and the billing is done in the name of the department head, a single payment record was prepared for any services of the radiology department and a separate payment record for any services of the pathology department.

2. Diagnostic Laboratory Fees Reimbursed at a Negotiated Rate

Beginning October 30, 1972, services performed in a laboratory that are billed on an assignment basis may be reimbursed at 100 percent of a negotiated rate with no deductible or coinsurance applied. This applies only to those laboratories who have negotiated a rate agreement with the carrier.

3. Independent Physical Therapists

Beginning July 1, 1973, services performed by an independent physical therapist in the therapist's office or in the patient's home became covered up to a maximum of $100 a year. A separate payment record is prepared for each bill for services performed by an independent therapist until the maximum expense has been incurred.

Note: Although separate payment records are prepared for the above types of service, the beneficiary, physician, calendar year relationship must still exist in all payment records produced.

Whenever payment is made for purchase of durable medical equipment, a payment record is also prepared. If the payments are spread out over a period of months a payment record is also prepared for each payment even though monthly bills are not submitted.

The 1967 Amendments established effective January 1, 1968, a separate Part B blood deductible. This deductible is equal to the charge for the first three (3) pints of blood furnished an individual in a calendar year. When a Request for Payment is received for blood charges, no payment record is prepared if those charges represent blood used to satisfy the Part B blood deductible. Charges for blood after the blood deductible has been satisfied and for which payment is made, requires the preparation of a payment record.

Deviations are not made from the procedures discussed above for preparing payment records on a "bill" basis. In addition, the format of the payment records and codes to be used for individual fields must conform exactly to those detailed in Exhibit A.

Contents of the Payment Record

For purposes of this manual, a complete description of payment records used in statistical programs is available in Exhibit A. Generally, carriers code all fields using the same coding criteria. However, some hospitals claim reimbursement for hospital-based physicians' services on Form SSA-1554 on a per diem or other unit of time basis. This method is used by a few hospitals that charge a fixed, all-inclusive rate computed on a per diem, per visit, or other time basis, which is applicable uniformly to each patient regardless of services received and without distinction between hospital services and physicians'

services. Where hospitals claim reimbursement for hospital-based physicians on a per diem or unit time basis and submit SSA-1554's without specifying the department providing treatment, a single abbreviated payment record per SSA-1554 is prepared. Where hospitals claim reimbursement for hospital-based physicians' services on a per diem or per visit time basis but provide details of service on a departmental basis or where hospitals do not use the per diem or per unit time method, completely coded payment records are prepared and submitted.

Payment Record Contents

	Information	Dec. Size	Usage 1/		Location	Description
1.	Record Length	4	C3	3	1-3	Constant +175.
2.	Claim Number					
	Account Number	9	X	9	4-12	
	Claim Symbol	2	X	2	13-14	
3.	Record Identification Code	1	X	1	15	Constant "R".
4.	ZIP Code	5	C3	3	16-18	Beneficiary's ZIP Code obtained from Master Record.
5.	Administrative Field	7	C3	5	19-23	Not used in statistical operations.
6.	Entry Code	1	X	1	24	A code for type of payment record being submitted: 1-Original debit 2-Supplemental debit 3-Full credit 4-Partial credit 5-Replacement debit 6-Partial debit
7.	Entry Recode	1	X	1	25	Status code indicating that a record is an initial submittal, a resubmittal, an initial reject, or a resubmitted reject. 1, 3, 5, 7 & 9-Initially submitted, accepted records. 2, 4, 6 & 8-Resubmitted accepted records. A, C, E & G-Initially submitted, rejected records. B, D, F & H-Resubmitted rejected records. X-Acknowledge an A reject previously submitted.
8.	Blank	1	X	1	26	
9.	Administrative Field	2	X	2	27-28	Not used in statistical operations.
10.	Name					
	Surname	6	X	6	29-34	Full surname up to 6 characters.
	First Initial	1	X	1	35	
11.	Blank	1	X	1	36	
12.	Administrative Field	5	C3	4	37-39	Not used in statistical operations.

	Information	Dec. Size	Usage 1/		Location	Description
13.	Administrative Field	1	X	1	40	Not used in statistical operations.
14.	Physical Therapy Indicator	1	X	1	41	0-No physical therapy involvement 1-Physical therapy involvement
15.	Reject Code	1	X	1	42	Field will contain the reason for rejection if the record is rejected in the HDHIDUP operation.
16.	Administrative Field	1	9	1	43	Not used in statistical operations.
17.	Receipt Date-SSA	5	C3	3	44-46	YYDDD-Date of receipt into EDP system.
18.	Process Date-SSA	5	C3	3	47-49	YYDDD-Date processed by HDHIDUP operation.
19.	Administrative Field	2	X	2	50-51	Not used in statistical operations.
20.	Original Reason for Entitlement	1	X	1	52	0-(OASI) 1-DIB (HR-1) 2-Renal 3-Both
21.	CRD Indicator	1	X	1	53	0-No CRD A-MBR notice of CRD B-HI notice of CRD C-NIH notice of CRD D-MBR/HI notice of CRD E-MBR/NIH notice of CRD F-HI/NIH notice of CRD G-MBR/HI/NIH notice of CRD
22.	Administrative Field	2	X	2	54-55	Not used in statistical operations.
23.	Carrier Bill Dates a. Date Bill Received	5	C3	3	56-58	YYDDD-Year and Julian Date the bill is received by carrier. Code 999 is used for diary records prepared after the initial payment as might occur in the purchase of durable medical equipment.

	Information	Dec. Size	Usage 1/		Location	Description
	b. Date Bill Paid	5	C3	3	59-61	YYDDD-Year and Julian Date carrier indicates on the benefit check. Where the carrier makes payment to physicians on a periodic basis through pre-arrangement, the date paid reflects the date the carrier would have ordinarily prepared the check if the physician were not reimbursed on a periodic basis.
24.	Previous Reject Code	1	X	1	62	(On resubmitted previously rejected record only.)
25.	Carrier Number	5	X	5	63-67	Unique identification number assigned by SSA.
26.	Expense Dates					Period for which expense incurred.
	First Expense Date	5	C3	3	68-70	YYDDD-Indicates first day of month in which expense period began.
	Last Expense Date	5	C3	3	71-73	YYDDD-Indicates first day of the month in which expense period ended.
27.	Outpatient Psychiatric Charges	5	C3	3	74-76	The outpatient psychiatric expense represents 62½% or $312.50 (whichever is less) of the reasonable psychiatric charges for the items on the Request for Payment Form for which payments have been made. This field is right justified.
28.	Reimbursement Amount	6	C3	4	77-80	$$$$¢¢-Signed field zeroes filled, right justified. The amount of payment made to or on behalf of the beneficiary.
29.	Administrative Field	1	X	1	81	Not used in statistical operations.
30.	Carrier Batch Number	1	9	1	82	Y-Unit position of the year in which batch was created.
	Batch Year Batch Month	2	9	2	83-84	MM-Month in which the batch was created. A "9" in the left order field signifies an internal batch payment record.

	Information	Dec. Size	Usage 1/		Location	Description
	Batch Sequence Number	2	9	2	85-86	01-99. 01-69--Payment batches. 70-99--Correction batches.
31.	Administrative Field	7	X	7	87-93	Not used in statistical operations.
32.	Current Reason for Entitlement	1	X	1	94	0-No DIB or Renal 1-DIB (HR-1) 2-Renal 3-Both conditions present
33.	Reasonable Medical Charges (Non-Psychiatric)	6	C3	4	95-98	$$$$¢¢ The reasonable charges for the non-psychiatric items on the Request for Payment form for which payment has been made. The monthly payment amount (before application of any deductible or coinsurance) is used for diary records prepared after the initial payment as might occur in the purchase of durable medical equipment. This field is right justified. NOTE: Payment records submitted for payment of services of an independent physical therapist contain a "P" in the high order position of this field.
34.	Deductible Applied	4	C3	3	99-101	$$¢¢-Signed field, zeroes filled, right justified. Amount of incurred expenses in this record which were applied to the deductible. All nines in field indicates 100% reimbursement.
35.	Carrier Control Number	7	X	7	102-108	Unique control number assigned each payment record by carrier.
	Control Number Check Character	1	X	1	109	Assigned by SSA to ensure unique control for identification of each payment record.
36.	Blanks	2	X	2	110-111	
37.	If Year Bill Paid is Prior to 76: Number of Separate Charges or	1	X	1	112	See Items 39b

	Information	Dec. Size	Usage 1/		Location	Description
	If Year Bill Paid is After 75: Format Indicator	1	X	1	112	"N" to signify new format.
38.	Physician or Supplier Identification Code	9	X	9	113-121	The number used to identify each individual physician, group, clinic or medical supplier, ambulance service, clinical laboratory, medical supply house, etc. Social Security Account Numbers are to be used for solo-practice physicians and sole-proprietorship suppliers where the request for payment is reimbursed on a fee for service basis. Solo-practicing physicians and/or suppliers are those physicians (suppliers) who bill only for their own services and in their own names. Clinics and other group practices, hospitals, etc., although billing as a single entity, are generally not considered solo practitioners for purposes of this section. However, the social security number of the individual physician should be used for physicians in group practice wherever bills are submitted on SSA-1490's in the name of individual physicians. Employer Identification Number The EI number is to be used when identifying groups, partnerships or clinics. EI numbers are also used for independent laboratories, group practice prepayment plans and other entities who bill in a group or company's name including physicians billing through a provider as hospital-based physicians. Other Identification Numbers Unique identification numbers assigned by the carriers are to be used if the social

	Information	Dec. Size	Usage 1/		Location	Description
						security or employer identification number is not available. Such usage should be very limited and occur only until valid Social Security or EI numbers can be obtained. NOTE: Vendors providing services outside the U.S. are assigned a unique number also. (The provider number assigned by SSA or if none available, a carrier assigned number.)
39.	If Year Bill Paid is Prior to 76: Largest Single Reasonable Charge Amount or If Year Bill Paid is After 75:	3	X	3	122-124	$$$-Unsigned field. Amount of money, rounded to the nearest dollar, for the single item of service on the bill, which is determined to have the largest reasonable charge.
	a. Sex Code	1	X	1	122	1-Male 2-Female
	b. Number of Separate Charges	2	X	2	123-124	A count of the number of separate covered charges which the carrier has taken into consideration when making the reasonable charge determination. When a series of similar services are represented by an inclusive single charge, each occasion of service is counted as a separate charge. Ninety-nine is used for 99 or more separate charges. For per diem records, zone "xx" punches will be shown.
40.	Place of Service	1	X	1	125	Code for place of service for largest single amount shown above: 1-Office 2-Home 3-Inpatient hospital 4-ECF/Nursing Home 5-Outpatient hospital 6-Independent laboratory 7-Other 8-Independent Kidney Disease Treatment Center

	Information	Dec. Size	Usage	1/	Location	Description
41.	Type of Service	1	X	1	126	Code for type of service for largest single amount shown above: 1-Medical care 2-Surgery 3-Consultation 4-Diagnostic X-Ray 5-Diagnostic laboratory 6-Radiation therapy 7-Anesthesia 8-Assistance at surgery 9-Other medical service 0-Charges for whole blood or packed red blood cells A-Purchase or rental of used DME (Effective 11/77 Y-Surgical second opinion (Effective 03/78) Z-Surgical third opinion (Effective 03/78) Blank for per diem records. The following are definitions of type of service used in assigning the codes listed above: 1. Medical care-Includes all physician services, including podiatrists and surgical chiropodists not elsewhere classified, and covers office visits, home visits, nursing home visits, and nonsurgical hospital visits. Psychiatric services, diagnostic services, allergy testing, therapeutic procedures, special dermatological procedures, and physical medicine services are also included. Consultation is excluded. 2. Surgery-Includes those procedures recognized in the surgical section of Current Procedural Terminology published by the AMA and covers services pertaining to incision, excision, repair, suture, destruction, introduction, fractures, manipulation, dislocations, amputation, and endoscopy. 3. Consultation-Refers to the professional service rendered by a physician whose opinion or advice has been requested by another physician or agency for the evaluation and/or treatment of a patient.

Information	Dec. Size	Usage 1/	Location	Description
				4. Diagnostic X-Ray-X-Ray and related services undertaken for diagnostic purposes. Includes portable X-Ray services after 12/31/67.
				5. Diagnostic laboratory-Laboratory services, regardless of where rendered, required in the diagnosis of disease or injury. Also includes certain mechanical or machine tests such as EKG, EEG, BMT, etc.
				Ultrasound diagnostic procedures performed after 12/31/74 are also shown under this code.
				6. Radiation therapy-Therapeutic services, such as X-Ray, radon, radium, and isotopes for the treatment of malignancies, tumors of bones, brain, or spinal cord, angiomas, vascular nevi, lymphomas, leukemia and thyroid disease.
				7. Anesthesia-Services for anesthesia including the appropriate pre- and post-operative visits, administration of anesthestic, and transfusion of fluids and/or blood incident to the anesthesia or surgery.
				8. Assistance at Surgery-Surgical assistance rendered upon the request of the primary surgeon and governed by the rules for such service prescribed by the carrier.
				9. Other medical services-Services falling in the following special categories:
				Rental of durable medical equipment.
				Purchase of durable medical equipment after 12/31/67.
				Ambulance service

Information	Dec. Size	Usage 1/	Location	Description
				Internal and external prosthetic devices and appliances.
				Supplies.
				0-Charges for Whole Blood or Packed Red Blood Cells- Includes bills where the charges are for whole blood or packed red blood cells and where reimbursement is made.
				A-Purchase or Rental of Used Durable Medical Equipment Effective November 1977 specific carriers were authorized to reimburse beneficiaries/ suppliers 100 percent of the reasonable charge for purchase or rental of used DME if such charge does not exceed 75 percent of the cost of new DME. (Deductible must still be met.) Initially only six carriers were involved. Additional carriers may be added subsequently.
				Y-Surgical Second Opinion Effective March 1978 carriers are authorized to pay claims for patient-initiated second physician opinions pertaining to the medical need for surgery. Beneficiaries are responsible for applicable deductible and coinsurance amounts.
				Z-Surgical Third Opinion Effective March 1978 carriers are also authorized to pay claims for patient-initiated third physician opinions pertaining to the medical need for surgery. As in type of service Y, beneficiaries are responsible for applicable deductibles and coinsurance amounts. Third opinion requests may occur if the initial and second physician opinions differ regarding the medical need for such surgery.

	Information	Dec. Size	Usage 1/		Location	Description
42.	Type of Physician or Supplier ID Number	1	X	1	127	Code "1" Physicians or suppliers billing as solo-practitioners for whom SS numbers are shown in the physician ID code field. "2" Physicians or suppliers billing as solo-practitioners for whom SS numbers are not available and the carrier's own physician ID code is shown. "3" Suppliers (other than sole proprietorship) for whom employer identification numbers are used in coding the ID field. "4" Suppliers (other than sole proprietorship) for whom employer ID numbers are not known and the carrier's own code has been shown. "5" Hospitals (including hospitals billing for hospital-based physicians) and independent laboratories for whom EI numbers are used in coding the ID field. "6" Hospitals (including hospitals billing for hospital-based physicians) and independent laboratories for whom EI numbers are not available and provider numbers assigned by SSA are shown. "7" Clinics, groups, associations, or partnerships for

Information	Dec. Size	Usage 1/	Location	Description
				whom EI numbers are used in coding the ID field. "8" Group practice prepayment plans for whom EI numbers are used in coding the ID field. "0" Clinics, groups, associations, partnerships, or GPPP's for whom EI numbers are not available and therefore the carrier's own physician code has been assigned. NOTE: A physician in solo practice, refers to a doctor who bills only for his own services and in his own name. A physician who is a member of a group but is billing in his own name is also considered as in solo practice. Where Medicare billing procedure requires that the individual physician number be shown in payment records, these physicians are considered as solo also. A sole proprietorship supplier refers only to an individual (supplying services other than physician services) who is the sole owner of the business and bills in his own name and not for multiple owners. Suppliers other than sole proprietorship are those supplying services other than physician service where more than one individual owns the business, i.e., partnerships, corporations, groups, etc. "Hospitals" include home health agencies and skilled nursing facilities as well as hospitals. Clinics, groups, associations, or partnerships, are defined as two or more physicians who have formed a unit of association and the billing procedure

	Information	Dec. Size	Usage 1/		Location	Description
						permits the use of the group identification number in the payment record. The group may consist of physicians with the same specialties or with a variety of specialties. However, the group employer identification number may be used in payment records only for those groups where charges for the same procedure are uniform for all physicians who are members of the group.
43.	Payment Code	1	X	1	128	A code indicating whether the payment being recorded was made to the beneficiary, to the physician or supplier, to both (partial payment to both the beneficiary and the physician or supplier on the same bill) or to a provider where the provider bills for the physician. Coded as follows: "1"-For payment to physician or supplier "2"-For payment to beneficiary "3"-For partial payment to both "4"-For payment to hospital (hospital-based physicians) "5"-For partial payment to both hospital and beneficiary "6"-For payment to group practice prepayment plan "7"-For payment to other entities; e.g., employer, union "8"-For payment to all Federally funded entities NOTE: a. If beneficiary is deceased and payment would have been made to him if alive, payment

	Information	Dec. Size	Usage 1/	Location	Description
					code "2" is used. b. Payment codes 4 and 5 include hospitals, skilled nursing facilities, or home health agencies where payment for the physicians' services are made directly to the facility.
44.	Physician or Supplier Specialty Code	2	X	2 129-130	A two-digit code for each physician or supplier of medical services dealing with the carrier showing the physician's specialty or the type of supplier. (See Exhibit B for valid specialty codes). Only one specialty code will normally be used for a given physician or supplier. However, when hospitals bill for services, more than one specialty code may be shown for the same EI number. A physician may be a member of a group and also engage in private practice. The group specialty code and group ID number are shown on bills representing the association. The physician's major specialty code and ID number, however, should be shown for bills resulting from his private practice. The clinic specialty code (70) should be used only where all of the following conditions are met: (1) The association consists of physicians with mixed (more than one) specialties, (2) Charges are uniform for a medical procedure regardless of the individual physician performing the service, (3) The request for payment is submitted in the name of the association and not the physician who performed the service.

	Information	Dec. Size	Usage 1/		Location	Description
						An association of two or more physicians may be considered a group (other than clinic) if both (2) and (3) above are met and the physicians involved are all one specialty. The group should be assigned the code applicable to that specialty. Field will be blank for per diem records.
45.	Region Code	1	X	1	131	Reflects the region of the carrier recording the payment: A-Boston B-New York C-Philadelphia D-Atlanta E-Chicago F-Dallas G-Kansas City H-Denver I-San Francisco J-Seattle K-Railroad Board L-Social Security
46.	Exception Code	1	X	1	132	A code reflecting reason for payment record reject. Possible codes: Blank-Record accepted A-Name/Number exception B-Beneficiary never entitled to Part B C-Payment record does not crossfoot D-Invalid month of expense E-No entitlement in the month of expense F-Last month of expense is later than beneficiary month of death (one month tolerance) G-Deductible not satisfied H-Deductible in payment record exceed $50 or $60 I-Invalid entry code J-Blood charges with no previous query containing blood K-Radiology/Pathology or Diagnostic Lab testing

	Information	Dec. Size	Usage 1/		Location	Description
						L-Psychiatric monies exceed the maximum M-Physical therapy reject N-Physical therapy monies exceed the maximum P-HMO lockin
47.	Administrative Field	22	X	22	133-154	Not used in statistical operations.
48.	Administrative Field	5	C3	3	155-157	Not used in statistical operations.
49.	State Code	2	X	2	158-159	Source-HI Master Record
50.	County Code	3	X	3	160-162	Source-HI Master Record
51.	Date of Birth	5	C3	3	163-165	YYDDD-Source HI Master Record
52.	Sex	1	X	1	166	Source-HI Master Record 0-Unknown 1-Male 2-Female
53.	Race	1	X	1	167	Source-HI Master Record 0-Unknown 1-White 2-Black 3-Other
54.	Administrative Field	9	X	9	168-174	Not used in statistical operations.
55.	Record Mark	1	X	1	175	End of record.

1/ 9-Numeric character
X-Alpha-numeric characters
C3-IBM Packed Decimal Field

Physician and Supplier Specialty Codes

For each request for payment involving physicians' services, carriers code the specialty of each physician rendering services. The 2 digit codes used are:

Code	Physician Specialization
01	General Practice
02	General Surgery
03	Allergy
04	Otology, Laryngology, Rhinology
05	Anesthesiology
06	Cardiovascular Disease
07	Dermatology
08	Family Practice
09	Gynecology (Osteopaths only)
10	Gastroenterology
11	Internal Medicine
12	Manipulative Therapy (Osteopaths only)
13	Neurology
14	Neurological Surgery
15	Obstetrics (Osteopaths only)
16	OB - Gynecology
17	Ophthalmology, Otology, Laryngology Rhinology (Osteopaths only)
18	Ophthalmology
19	Oral Surgery (Dentists only)
20	Orthopedic Surgery
21	Pathologic Anatomy; Clinical Pathology (Osteopaths only)
22	Pathology
23	Peripheral Vascular Diseases or Surgery (Osteopaths only)
24	Plastic Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Psychiatry, Neurology (Osteopaths only)
28	Proctology
29	Pulmonary Diseases
30	Radiology
31	Roentgenology, Radiology (Osteopaths only)
32	Radiation Therapy (Osteopaths only)
33	Thoracic Surgery
34	Urology
35	Chiropractor, licensed (effective July 1973)

Code	Physician Specialization
36	Nuclear medicine
37	Pediatrics
38	Geriatrics
39	Nephrology
40	Hand Surgery
48	Podiatry - Surgical Chiropody
49	Miscellaneous
70	Clinic or other group practice, except GPPP (See note below)
99	Unknown

Individual physicians are considered specialists if they consider themselves specialists and so classify themselves regardless of whether or not they are certified by specialty boards or eligible for certification. For physicians with more than one specialty, the carrier enters the major specialty of the physician on all his payment records and does not vary the specialty code with the different types of service reported for that physician.

NOTE: Use of code "70" above. Clinic code "70" is used:

(a) only where charges are uniform for a medical procedure regardless of the individual physician in the group or clinic performing the service; and

(b) only for those groups composed of physicians with mixed (two or more) specialties; and

(c) only where the request for payment does not identify the performing physician but is submitted in the name of the group.

Groups whose physician members are all one specialty should be assigned the code applicable to that specialty. Specialty code "70" should not be used for such groups.

NOTE: Specialty code use for services in an independent laboratory:

For services performed in an independent laboratory, if the request for payment was submitted by the physician ordering the tests or x-rays, this physician's specialty code will be shown. If the request for payment is submitted by the independent laboratory, type of supplier code "69" shown below will be used.

Coding Type of Supplier.--Requests for payment involving services by suppliers other than physicians are coded with a type of supplier code as shown below:

Code	Type of Supplier
51	Medical supply company with C.O. (Certified orthotist-certified by American Board for Certification in Prosthetics and Orthotics) certification
52	Medical supply company with C.P. (Certified prosthetist-certified by American Board for Certification

Code	Type of Supplier
52 (con't)	in Prosthetics and Orthotics) certification
53	Medical supply company with C.P.O. (Certified) prosthetist-orthotist-certified by American Board for Certification in Prosthetics and Orthotics) certification
54	Medical supply company not included in 51, 52 or 53
55	Individual CO
56	Individual CP
57	Individual CPO
58	Individuals not included in 55, 56, or 57
59	Ambulance service supplier, e.g., private ambulance companies, funeral homes, etc.
60	Public Health or Welfare Agencies (Federal, State and local)
61	Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities, Inc., etc.)
62	Psychologist (Billing Independently)
63	Portable X-Ray Supplier (Billing Independently)
64	Audiologists (Billing Independently)
65	Physical Therapist (Independent Practice) (July 1973)
69	Independent Laboratory (Billing Independently)
87	All other, e.g., Drug and Department Stores
88	Unknown

Coding Type of Service for Group Practice Prepayment Plans.--The following codes are used to code type of service only for bills submitted by group practice prepayment plans on Forms SSA-1556. These codes are used only for services that do not involve a "visit" to a physician. A "visit" to a physician is defined as a formal face-to-face contact between the physician and the patient for purposes of diagnosis or treatment. For bills involving a "visit" to a physician, the specialty of the physician providing services are coded using the physician specialty codes 01-40, 48-49, 70 or 99.

Code	Type of Service
71	Diagnostic X-Ray
72	Diagnostic Laboratory
73	Physiotherapy
74	Occupational Therapy
75	Other Medical Care

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

PREPAYMENT PLAN FOR GROUP MEDICAL PRACTICES DEALING THROUGH A CARRIER

MEDICAL INSURANCE BENEFITS – SOCIAL SECURITY ACT

Exhibit C
Form Approved.
OMB No. 72-R0773

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

NAME AND ADDRESS OF GROUP PRACTICE PREPAYMENT PLAN	Copy from HEALTH INSURANCE CARD	NAME OF PATIENT ADDRESS *(Street address, City, State, ZIP Code)*	
	GPPP NO.	CLAIM NUMBER	☐ MALE ☐ FEMALE

REPORT OF SERVICES – SEE INSTRUCTIONS ON REVERSE SIDE

1. a DATE OF EACH VISIT OR SERVICE	b PLACE OF VISIT OR SERVICE[2]	c PHYSICIAN SPECIALTY OR SUPPLIER CODE[1]	d FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	e DIAGNOSIS	f CHARGES	LEAVE BLANK

3. ARE ANY SERVICES, ILLNESSES OR INJURIES DESCRIBED IN ITEM 1 EMPLOYMENT RELATED?
☐ Yes ☐ No *(If "yes," indicate which one(s) and give name and address of employer below.)*

2. TOTALS		
4. Deductible and coinsurance paid		
5. Any unpaid balance		

The above named organization has in file and currently in effect an assignment by this patient of amounts payable under Part B of Title XVIII of the Social Security Act for medical services furnished him by it or under arrangements made by it. The organization hereby accepts such assignment with the understanding that under its terms the reasonable charge for any service as determined by the carrier shall be the full charge for the service.

6. SIGNATURE OF AUTHORIZED REPRESENTATIVE OF GROUP PRACTICE PREPAYMENT PLAN	7. DATE

[1] *See reverse for listing of codes to be used in this block.*

[2] O–Doctor's Office C–Clinic IH–Inpatient Hospital ECF–Extended Care Facility IL–Independent Laboratory *(give name & address in 1D)*
H–Patient's Home OH–Outpatient Hospital NH–Nursing Home OL–Other Locations *(Specify in 1D)*

FORM SSA-1556 (10-70)

Instructions for Completing Report of Services

1A–*Date of Each Visit or Service.*–Enter the date for each service including both services which involved a *visit*, i.e., a face to face contact with a physician, and the services which did not involve a *visit*. (See the "Guidelines for Reimbursement of Group Practice Prepayment Plans" for a full definition of a *visit*.)

1B–*Place of Service.*–Enter the appropriate letter code from the footnote on the form.

1C–*Physician Specialty or Supplier Code.*–Show the appropriate code from the list below.

1D–Describe in specific medical terms all surgical or medical procedures and treatment furnished to the beneficiary.

1E–*Diagnosis.*–Furnish the professional description of the diagnosis.

1F–Enter charges only for the line items which represent services involving a *visit*. (See 1A instruction above.)

Physician Specialty Code	Physician Specialization
01	General Practice
02	General Surgery
03	Allergy
04	Otology, Laryngology, Rhinology
05	Anesthesiology
06	Cardiovascular Disease
07	Dermatology
08	Family Practice
09	Gynecology (Osteopaths only)
10	Gastroenterology
11	Internal Medicine
12	Manipulative Therapy (Osteopaths only)
13	Neurology
14	Neurological Surgery
15	Obstetrics (Osteopaths only)
16	OB – Gynecology
17	Ophthalmology, Otology, Laryngology, Rhinology (Osteopaths only)
18	Ophthalmology
19	Oral Surgery (Dentists only)
20	Orthopedic Surgery
21	Pathologic Anatomy; Clinical Pathology (Osteopaths only)
22	Pathology
23	Peripheral Vascular Diseases or Surgery (Osteopaths only)
24	Plastic Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Psychiatry, Neurology (Osteopaths only)
28	Proctology
29	Pulmonary Diseases
30	Radiology
31	Roentgenology, Radiology (Osteopoths only)
32	Radiation Therapy (Osteopoths only)
33	Thoracic Surgery
34	Urology
48	Podiatry
49	Miscellaneous
99	Unknown
NA	To be used only until Jonuory 1, 1967

Identify the type of supplier involved using the following 2-digit codes–

Code	Type of Supplier
51	Medical supply company with C.O. (Certified orthotist-certified by American Board For Certification in Prosthetics and Orthotics) certification
52	Medical supply company with C.P. (Certified prosthetist-certified by American Board for Certification in Prosthetics and Orthotics) certification
53	Medical supply company with C.P.O. (Certified prosthetist-orthotist-certified by American Board for Certification in Prosthetics and Orthotics) certification
54	Medical supply company not included in 51, 52 or 53
55	Individual CO
56	Individual CP
57	Individual CPO
58	Individual not included in 55, 56, or 57
59	Ambulance service supplier, e.g., private ambulance companies, funeral homes, etc.
60	Public Health or Welfare Agencies (Federal, State, Local)
61	Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities, Inc., etc.)
69	All other, e.g., Drug and Department Stores (trusses)
*71	Diagnostic X-ray
*72	Diagnostic laboratory
*73	Physiotherapy
*74	Occupational Therapy
*75	Other medical care
88	Unknown
NA	To be used only until January 1, 1967
(Not Available)	

*Use these codes only when the specified services did not involve a "visit" to a physician.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1975—210-831/60 2-1

Exhibit D

REQUEST FOR MEDICARE PAYMENT

Form Approved OMB No. 72-R0730

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See Instructions on Back—Type or Print Information)

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

Copy from YOUR OWN HEALTH INSURANCE CARD (See example on back)

1 Name of patient (First name, Middle initial, Last name)

2 Health Insurance claim number (Include all letters) ☐ Male ☐ Female

3 Patient's mailing address — City, State, ZIP code — Telephone Number

4 Describe the illness or injury for which you received treatment (Always fill in this item if your doctor does not complete Part II below) — Was your illness or injury connected with your employment? ☐ Yes ☐ No

5 If any of your medical expenses will be or could be paid by another Insurance organization or government agency (including FEHB), show below.
Name and address of organization or agency — Policy or Identification Number

Note: If you Do Not want information about this Medicare claim released to the above upon its request, check (X) the following block ☐

6 I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

SIGN HERE — Signature of patient (See instructions on reverse where patient is unable to sign) — Date signed

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7 A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given — Procedure Code	D. Nature of illness or injury requiring services or supplies (diagnosis)	E. Charges (If related to unusual circumstances explain in 7C)	Leave Blank
				$	

8 Name and address of physician or supplier (Number and street, city, State, ZIP code)

Telephone No. — 9 Total charges $

Physician or supplier code — 10 Amount paid $

11 Any unpaid balance due $

12 Assignment of patient's bill ☐ I accept assignment (See reverse) ☐ I do not accept assignment.

13 Show name and address of person or facility which furnished service (if other than your own office or patient's home)

14 Signature of physician or supplier (A physician's signature certifies that a physician's services were personally rendered by the physician or under the physician's personal direction). — Date signed

*O—Doctor's Office IL—Independent Laboratory H—Patient's Home (If portable X-ray services, identify the supplier) IH—Inpatient Hospital SNF—Skilled Nursing Facility OH—Outpatient Hospital OL—Other Locations NH—Nursing Home

FORM SSA 1490 (C) (S) (11-75)

Department of Health, Education, and Welfare
Social Security Administration

PROVIDER BILLING FOR PATIENT SERVICES BY PHYSICIANS

MEDICAL INSURANCE BENEFITS — SOCIAL SECURITY ACT

(Use this form only where the provider has billing arrangement to collect physician charges for individual patient care pursuant to agreement with the physician.)

Exhibit E

Form Approved.
OMB No. 72–R747

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal la

1. PATIENT'S LAST NAME	FIRST NAME	MI	2. SEX ☐ M ☐ F	3. HEALTH INSURANCE CLAIM NUMBER

4. PATIENT'S ADDRESS *(Street number, City, State, Zip Code)*	5. DATE OF BIRTH	6. MEDICAL RECORD NO.

7. NAME AND ADDRESS OF PROVIDER	7a PROVIDER NO.

8. If the patient wishes to authorize release of information about this claim upon its request to another organization which provides health insurance for him, or to his State medical assistance agency, please give the following information.

INSURING ORGANIZATION OR STATE AGENCY NAME AND ADDRESS	POLICY OR MEDICAL ASSISTANCE NUMBER

9. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment below.

☐ SIGNATURE CONTAINED IN PROVIDER'S RECORD	SIGNATURE *(Patient or authorized representative) (Signature by mark must be witnessed)*	DATE

10A. DATE OF EACH SERVICE	B. PLACE OF SERVICE (1)	C. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES	D. PHYSICIAN IDENTIFICATION INFORMATION		E. CHARGE FOR PHYSICIANS SERVICES	LEAVE BLANK
			NAME OF PHYSICIAN/DEPARTMENT			
			TOTAL CHARGE	PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT			
			TOTAL CHARGE	PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT			
			TOTAL CHARGE	PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT			
			TOTAL CHARGE	PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT			
			TOTAL CHARGE	PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT			
			TOTAL CHARGE	PERCENT OF CHARGE		

(1) CODES. IH-INPATIENT HOSPITAL, OH-OUTPATIENT HOSPITAL, ECF-EXTENDED CARE FACILITY, H-HOME HEALTH AGENCY.

11. DIAGNOSIS AND CONCURRENT CONDITIONS	TOTALS	$	
	Amount paid by Beneficiary		
12. EMPLOYMENT RELATED *(If "Yes," give name and address of employer)* ☐ YES ☐ NO	Any unpaid Balance		

13. PROVIDER CERTIFICATION: The physicians who performed the services described above have authorized the provider to accept assignment and receive payments in their behalf (and such authorizations are on file and still in effect.)

SIGNATURE OF PROVIDER REPRESENTATIVE	DATE

FORM SSA-1554 (2) (10-69)

Department of Health, Education, and Welfare
Social Security Administration

VI. Stay Records

Introduction

The Inpatient Hospital Stay Record contains information about a person's stay in a hospital from admission through discharge for a 20 percent sample of Medicare enrollees. Stay records are used to compile a very large portion of the health insurance utilization statistics such as the annual short-stay hospital tabulations, current utilization tabulations, and MEDPAR files. This record contains utilization information from bills, demographic information about the enrollee, and provider information.

Billing and Demographic Information

The basic input for the hospital stay records are bills for inpatient hospital services submitted to SSA for Medicare payments by hospitals. Bills which have cleared the administrative process at SSA and have been updated to the Health Insurance Master Enrollment File (HIMA) are entered into the statistical system. When the bill record is updated to the HIMA the enrollees demographic characteristics such as age, sex, race, and State and county of residence are appended to it. The record sent for statistical processing contains both the billing information and a persons demographic characteristics. Chapter IV describes the complete contents of these records and the tabulations produced from them. For the hospital stay record operations, only the 20 percent sample of hospital bills are used.

All bills submitted for the same hospital stay are sorted and summarized, creating a bill summary record. As soon as the bill summary indicates that the patient has been discharged; i.e., a discharge bill has been received, the stay record showing information from date of admission to date of discharge is created. If the patient has not been discharged, the bill summary remains on the orbiting bill summary file until the discharge information is received.

All bills used for creating stay records contain a primary discharge diagnosis code, and an indication of whether or not there were additional diagnoses. The four digit ICDA eighth revision is used to code diagnosis. If surgery has been performed a surgical procedure code, an indication of additional surgical procedures, and date of surgery are also shown on the bill. The four digit current procedural terminology (CPT) manual is used to code surgical procedures.

Provider Information

Periodically stay records are matched to the Provider of Services file to append selected provider information to the stay records. This file contains detailed information about the characteristics of each hospital participating under Medicare. Some of these characteristics are location of the hospital, type of hospital, type of control and bed size. Chapter X of this manual contains a detailed description of the Provider of Services Master File.

SNF Stay Records

Stay records are also prepared for stays in Skilled Nursing Facilities. The SNF stay record is essentially the same as the hospital record except that instead of a 20 percent file, a 100 percent file is created. This is because

of the small volume (approximately 300,000 per year). SNF stay records contain an admitting diagnosis instead of the discharge diagnosis and there is no surgery. There are also dates of admission and discharge of the qualifying hospital stay.

Derivative Files

Exhibit A contains the contents of the 20 percent sample inpatient hospital stay record. Exhibit B contains the contents of the MEDPAR (Medicare Provider Analysis and Review) record. This was once known as the MADOC (Medicare Analysis of Days of Care) record. The MEDPAR record is derived completely from the inpatient hospital stay record. Each record contains selected items of information from the hospital stay record. The file of MEDPAR records is prepared every 6 months and contains 3 years of discharges, the current year and 2 previous years. For example, the file created at the end of December 1976 contains discharges from 1974 through 1976. The subsequent MEDPAR file after June 1977 contains discharges from 1975 through December 1977 based on inpatient hospital stay records created January 1977 through June 1977.

Exhibit C contains the contents of a skeleton hospital stay record which is produced annually for discharges in a given year with a 1 year lag. For example, after December 1976 a skeleton file containing discharges in 1975 is produced. This skeleton file is also produced with a 2 year lag from a hospital stay record file used to produce the annual short-stay hospital publication tables.

Exhibit D contains the contents of the inpatient SNF stay record.

Exhibit E contains the contents of a skeleton SNF stay record which is produced annually (beginning 1974) with a 1 year lag. This file contains not only discharges in a year, but also stays where benefits have been exhausted, but the final discharge status is unknown. These records are included because there are many long SNF stays where the final discharge bill does not come in until long after SNF benefits have been exhausted.

Inpatient Hospital Stay Record - 20% Sample

	Information	Number of Positions	Positions BEG	Positions END	Description
1.	HI Claim Number	11	1	11	If the first position of the claim number is $\frac{+}{0}$ thru G, it is a railroad account number. If not, it is a Social Security Number with the last two positions indicating the type of beneficiary.
2.	Transaction Code	1	12	12	1-Psychiatric hospital 2-Tuberculosis hospital 3-General Care hospital
3.	Date of Birth	5	13	17	YYDDD
4.	Sex	1	18	18	1-Male 2-Female 3-Unknown
5.	Race	1	19	19	1-White 2-Negro 3-Other 4-Unknown
6.	Beneficiary's State and County Code	5	20	24	First two positions-State code Last three positions-County code
7.	SSA-RRB Dual Entitlement Indication	1	25	25	0-No entitlement 1-Has dual entitlement
8.	State Buy-In	1	26	26	0-No 1-Yes
9.	Cross-Reference Account Number	11	27	37	Cross-reference claim number. (See positions 1-11 for format).
10.	Provider Number	6	38	43	Identification number of the provider submitting the claim. The third position of the provider indicates the type of hospital. 0-Short-stay 1-Christian Science ECF 2-Long-stay General & Special 3-Tuberculosis 4-Psychiatric 5-Regular SNF

	Information	Number of Positions	Positions BEG	Positions END	Description
11.	Admission Date	5	44	48	Date the beneficiary entered the care of the provider. (YYDDD)
12.	Discharge Date	5	49	53	Date the beneficiary left the care of the provider or died. (YYDDD)
13.	Formerly Disabled	1	54	54	0-No 1-Yes
14.	Discharge Status	1	55	55	0-Discharge Alive 1-Died
15.	Additional Diagnoses	1	56	56	0-Had no additional diagnoses 1-Had at least one additional diagnoses 9-Unknown
16.	Discharge Diagnosis	4	57	60	Four position code from the Discharge Bill indicating the final diagnosis. For a list of the Diagnostic Codes and their meanings refer to the manual: "International Classification of Disease Adapted"
17.	Surgery Indication 2/	1	61	61	0-Had no surgery 1-Had surgery
18.	Additional Surgical Procedures	1	62	62	0-Had no additional surgery 1-Had additional surgery 9-Unknown
19.	Surgery Code	4	63	66	Four position code indicating the type of surgery performed, if any.
20.	Beneficiary's SMSA	5	67	71	SMSA Size (position 67) SMSA Area code (positions 68-70) SMSA Central City Indication (71)
21.	GPPP Number	5	72	76	Group Practice Prepayment Plan
22.	Age at Admission	3	77	79	
23.	Intermediary Number	5	80	84	Identification number of intermediary processing the claim. Consult the

	Information	Number of Positions	Positions BEG	Positions End	Description
23.	Intermediary Number Con't.				"Directory of Medical Facilities" for the list of intermediary numbers.
24.	Participation Status	1	85	85	Fully participating with: 1-No significant deficiency 2-Correctable deficiency(s) 3-Special participation 1/
25.	Type of Hospital	1	86	86	1-General Short-stay 2-General Long-stay 3-TB 4-Psychiatric 5-Chronic Disease 6-Specialty Short-stay 7-Specialty Long-stay 8-Christian Science 9-All others BLANK-1/
26.	Control	1	87	87	Voluntary Non-Profit 1-Church 2-Other than Church Proprietary 3-Proprietary Government Non-Federal 4-State 5-County 6-City 7-City/County 8-Hospital District Federal Government 9-Public Health Service 0-Other than PHS BLANK-1/
27.	Provider's State and County Code	5	88	92	State and county code of the Provider 1/
28.	Provider's Standard Metropolitan Statistical Area Code	3	93	95	Refer to the Bureau of the Budget "SMSA" Manuals for a list of the codes and their meanings. 1/
29.	Not Used	3	96	98	
30.	Facilities	2	99	100	Number of facilities available 1/
31.	Medical Staff	4	101	104	Number of medical staff members 1/

	Information	Number of Positions	Positions BEG	Positions END	Description
32.	Size (Adult Bed Capacity)	4	105	108	Actual number of beds. 1/
33.	Joint Commission	1	109	109	BLANK or 0-No information 1-Has accreditation 2-Not accrediated 1/
34.	Medical School Affiliation	1	110	110	0-No information 1-Major 2-Limited 3-Graduate 4-No Affiliation BLANK-1/
35.	Approved Intern	4	111	114	(1-indicates yes for approval) 1st position-AMA 2nd position-ADA 3rd position-AOA 4th position-Number of intern programs BLANKS-1/
36.	Approved Resident	8	115	122	Field is broken into 4 two-position subfields. Anything other than blanks or zeroes indicates approval and number of programs available. 1st two positions-AMA number approved 2nd two positions-ADA number approved 3rd two positions-AOA number approved 4th two positions-Number of resident programs 1/
37.	Not Used	1	123	123	
38.	Not Used	1	124	124	
39.	Not Used	5	125	129	
40.	Date of Surgery	5	130	134	Date surgery performed. (YYDDD)
41.	Billing Date From	5	135	139	Beginning date covered in this stay (YYDDD)
42.	Billing Date To	5	140	144	Ending date of stay (YYDDD)

	Information	Number of Positions	Positions BEG	Positions END	Description
43.	Guarantee of Payment Date	5	145	149	Last day the provider is guaranteed payment of services on an uncertified beneficiary (YYDDD)
44.	Utilization Review	5	150	154	Date review of the patient's need for continued hospitalization (YYDDD)
45.	Date Active Care Ended	5	155	159	Date the active care ended. (TB and Psychiatric stays only.) (YYDDD)
46.	Date Benefits Exhausted	5	160	164	Date coverage was exhausted. (YYDDD)
47.	Forwarding Date	5	165	169	Date the final bill forwarded by the hospital. (YYDDD)
48.	Approval Date	5	170	174	Date the final bill approved by the intermediary. (YYDDD)
49.	Estimated Total Charge Indicator	1	175	175	1-Indicates that total charge field is estimated (not actual)
50.	Number of Bills Used for This Stay	2	176	177	Net total of bills used to create stay. (Credit adjustment only = -1)
51.	Type of Bills Used	1	178	178	1-Initial debit bills only 2-Debit adjustment bills only 3-Initial debit and debit adjustment bill 4-Credit adjustment bills only 5-Initial debit and credit adjustment 6-Debit adjustment and credit adjustment 7-Initial debit, debit only, and credit adjustment
52.	Date Stay Created	4	179	182	MMYY
53.	Block Number	8	183	190	First four positions-Julian date (YYDD) final

	Information	Number of Positions	Positions BEG	END	Description
53.	Block Number Con't.				bill received in SSA. Last four positions- control number assigned by SSA.
54.	Batch Number	8	191	198	First four positions- control number assigned the intermediary (NNNN) Fifth position-batch year (Y) Last three positions- Julian date batched by the intermediary (DDD)
55.	Total Charges	5	199	203	Whole dollar amount of the total of all expenses in this stay.
56.	Non-Covered Charges	5	204	208	Whole dollar amount of the total non-reimbursable expenses.
57.	Reimbursement	5	209	213	Whole dollar amount of the total of reimbursable expenses.
58.	Not Reimbursed	5	214	218	Whole dollar amount of the difference between the total charges and reimbursement amount.
59.	Coinsurance Amount	5	219	223	Whole dollar amount of the coinsurance incurred in this stay.
60.	Inpatient Deductible	3	224	226	Whole dollar amount of deductible expense incurred in this stay.
61.	Length of Stay	3	227	229	Total length of the hospital stay date of admission through date of discharge.
62.	Covered Days	3	230	232	Number of covered days in the stay.
63.	Lifetime Reserve Days Used	3	233	235	Lifetime reserve days used in stay.
64.	Coinsurance Days	3	236	238	Coinsurance days used in stay.

	Information	Number of Positions	Positions BEG	Positions END	Description
65.	Accommodation Days	3	239	241	Sum of all accommodation days used in stay.
66.	Accommodations Total Charges	5	242	246	Whole dollar amount of the total charges fields from all the accommodations.
67.	Accommodations Days and Charges	13	247	259	1 bed facility
		13	260	272	2-4 bed facility
		13	273	285	5 or more bed facility
	Each field has a 3 position days	13	286	298	Intensive care
	field, a 5 position total charges	13	299	311	Self-care
	field of dollars only and a	13	312	324	Periodic interim payment
	5 position covered charges field of dollars only.				
68.	Departmental Charges	5	325	329	Total whole dollar amount for services and related charges.
69.	Services Used and Related	10	330	339	Operation room
	Charges	10	340	349	Pharmacy
		10	350	359	Laboratory
	Each field has a 5 position	10	360	369	Radiology
	total charges field of	10	370	379	Medical, Surgical and
	dollars only and a 5				Central Supplies
	position covered charges	10	380	389	Anesthesia
	field of dollars only.	10	390	399	Inhalation Therapy
		10	400	409	Other Services
		10	410	419	Physical Therapy
		10	420	429	Occupational Therapy
		10	430	439	Speech Therapy
		10	440	449	Outpatient Services
		10	450	459	Blood Administration
70.	Blood Pints Used	2	460	461	Number of whole pints used.
71.	Blood Pints Replaced	2	462	463	Number of whole pints replaced.
72.	Blood Pints Not Replaced	2	464	465	Number of whole pints not replaced.
73.	Blood Deductible Pints	1	466	466	Number of whole pints of blood used in this stay toward deductible amounts.
74.	Blood Total Charges	5	467	471	Whole dollar amount of total charges for blood used (taken from the same code fields described in

	Information	Number of Positions	Positions BEG	Positions END	Description
74.	Blood Total Charges Con't.				the previous entry.)
75.	Blood Total Covered Charges	5	472	476	Whole dollar amount of covered charges for blood used.
76.	Blood Deductible Amount	3	477	479	Whole dollar amount of the blood used toward the deductible amount.
77.	Not Used	2	480	481	
78.	Medicare Status Code	2	482	483	Two position code to classify a beneficiary under 1972 amendments Tens Position 1-Aged 2-Disabled 3-Chronic Renal Disease Units Position 0-No CRD 1-CRD
79.	Original Reason for Entitlement (OREC)	1	484	484	Basis for first entitlement to HI benefits 0-OASI 1-DIB 2-Renal 3-Renal and DIB
80.	Current Reason for Entitlement (CREC)	1	485	485	Basis for beneficiary's current entitlement to HI benefits 0-OASI 1-DIB 2-Renal 3-Renal and DIB
81.	Renal Insured Status Indicator (RISI) and Prior Unqualify DIB Indicator (PUDI)	1	486	486	RISI denotes beneficiary's entitlement to HI benefits is based on fully or or currently insured worker's earnings and not on beneficiary's own earnings.

	Information	Number of Positions	Positions BEG	Positions END	Description
81.	Con't.				PUDI denotes beneficiary was previously disabled but not enough to qualify for HI on that basis. 0-Neither 1-RISI 2-PUDI 3-RISI and PUDI
82.	Chronic Renal Disease Indicator (CRDI)	1	487	487	Source of notification of CRD 0-No CRD A-MBR B-HI C-NIH D-MBR/HI E-MBR/NIH F-HI/NIH G-MBR/HI/NIH
83.	Blanks	2	488	489	
84.	ZIP Code of Residence	5	490	494	
85.	Record Mark	16	495	510	End of the stay record

Notes: 1/ These fields are not available in the bill records used to create this file. These fields will be initialized to blank or zero. If the information contained in these fields is required, a match to the Provider File will have to be made.

2/ Surgery indication is coded 1 (yes) if at least 2 out of the following 3 conditions exist:

1. Surgery code present
2. Date of surgery present
3. Operating room charges present

MEDPAR Record Contents

	Item	Number of Positions	Code	Field Position
1.	HI Claim Number	11	Actual Number	1-11
2.	Provider Number	6	Actual Number	12-17
3.	State and County of Residence	5	2-Digit State, 3-Digit County	18-22
4.	Professional Standard Review Organization (PSRO) Service Area Number	3	000 for single-PSRO States 001, 002, etc., for multiple PSRO states	23-25
5.	Discharge Date	6	6-Digit Number, Year, Month, Day	26-31
6.	Primary Discharge Diagnosis	4	ICDA-8 code	32-35
7.	Length of Stay	3	Date of Discharge minus Date of Admission. If difference is 0 make it 1.	36-38
8.	Age	3	Define age as a 3 position number, i.e., 066, 067, 068, etc., as of last birthday on date of admission.	39-41
9.	Sex	1	0-Female, 1-Male	42
10.	Race	1	0-Unknown, 1-White, 2-Negro, 3-Other	43
11.	Additional Diagnosis	1	1-Yes, 0-No	44
12.	Surgical Indication	1	1-Yes, 0-No	45
13.	Discharge Status	1	0-Alive, 1-Dead	46
14.	Day of Admission	1	1-Sunday, 2-Monday, 3-Tuesday, 4-Wednesday, 5-Thursday, 6-Friday, 7-Saturday	47
15.	Additional Surgery	1	1-Yes, 0-No	48
16.	Amount Reimbursed	5	Dollars only	49-53
17.	Intensive Care Charges	4	Dollars only, SSA-1453-line 19E	54-57
18.	Operating Room Charges	4	Dollars only, SSA-1453-line 19H	58-61
19.	Pharmacy Charges	4	Dollars only, SSA-1453-line 19L	62-65
20.	Laboratory Charges	4	Dollars only, SSA-1453-line 19N	66-69
21.	Radiology Charges	4	Dollars only, SSA-1453-line 19M	70-73

Item	Number of Positions	Code	Field Position
22. Supplies Charges	4	Dollars only, SSA-1453-line 190	74-77
23. Anesthesia Charges	4	Dollars only, SSA-1453-line 19I	78-81
24. Inhalation Therapy Charges	4	Dollars only, SSA-1453-line 19S	82-85
25. PSRO State Code	2	Actual number	86-87
26. Type of Hospital	1	1=General short term 2=General long term 3=Tuberculosis 4=Psychiatric 5=Chronic disease 6=Specialty short term 7=Specialty long term 8=Christian Science 9=Other	88
27. Total Charges	5	Dollars only	89-93
28. Coinsurance Days	2	SSA-1453, line 19X	94-95
29. ZIP Code of Beneficiary Residence	5	Actual Code	96-100
30. Number of Facilities and Services	2	01, 02, 03, etc.	101-102
31. Medical School Affiliation	1	No-0, Yes-1	103
32. Bed Capacity (Adult)	4	Actual number	104-107
33. Covered Days	3	SSA-1453, Box 28	108-110
34. Lifetime Reserve Days	2	SSA-1453, Box 26	111-112
34a. Type of Control	1	1=Government non-federal 2=Church 3=Proprietary 4=Federal 5=Other non-profit	113
35. Periodical Interim Payment	1	Yes-1, No-0, SSA-1453, line 19G	114
36. Date of Admission	6	6-digit number, year, month, day	115-120
37. Date of Surgery	6	6-digit number, year, month, day	121-126

	Item	Number of Positions	Code	Field Position
38.	Surgery Code	4	CPT code	127-130
39.	Blood Furnished (pints)	2	2-digit whole pints	131-132
40.	Intensive Care Days	3	Actual number from line 19E of SSA-1453	133-135
41.	Total Accommodation Charges	4	Dollars only, lines 19B plus 19C plus 19D from SSA-1453	136-139
42.	Type of Entitlement (Medicare Status Code)	2	Tens positions 1-aged 2-disabled 3-chronic renal disease Units position 0-no CRD 1-CRD	140-141
43.	Total Departmental (Ancillary) Charges	4	Dollars only, SSA-1453-Sum of lines 19H through 19T	142-145
44.	Covered Charges	5	Dollars only	146-150

Annual Hospital Stay Record Skeleton Write-Off

Information	Number of Characters	Positions
HI Claim Number	11	1- 11
Date of Birth	5	12- 16
Sex	1	17
Race	1	18
State of Residence	2	19- 20
County of Residence	3	21- 23
ZIP Code of Residence	5	24- 28
PSRO of Residence	3	29- 31
Provider Number	6	32- 37
County of Provider	3	38- 40
ZIP Code of Provider	5	41- 45
PSRO of Provider	3	46- 48
Medical School Affiliation	1	49
Date of Admission	5	50- 54
Date of Discharge	5	55- 59
Date Benefits Exhausted	5	60- 64
Discharge Status	1	65
Primary Discharge Diagnosis Sort Code	1	66
Primary Discharge Diagnosis	4	67- 70
Indication of Additional Diagnosis	1	71
Surgery Code	4	72- 75
Indication of Additional Surgery	1	76
Surgery Indication	1	77
Age at Admission	3	78- 80
Total Charges	5	81- 85
Covered Charges	5	86- 90
Amount Reimbursed	5	91- 95
Length of Stay	3	96- 98
Covered Days	3	99-101
Blank	1	102
Medicare Status Code	2	103-104
Inpatient Deductible	3	105-107
Blood Deductible ($)	3	108-110
Coinsurance Amount	5	111-115
Coinsurance Days	3	116-118
Lifetime Reserve Days	3	119-121
Block Number	8	122-129
Batch Number	8	130-137
Blanks	1	138

Note 1: All dates are Julian

Note 2: All money fields are rounded to whole dollars.

Inpatient SNF Stay Record

	Information	Number of Positions	Positions BEG	Positions END	Description
1.	HI Claim Number	11	1	11	If the first position of the account number is $\overset{+}{0}$ through G, it is a Railroad Account Number. If not, it is a Social Security Number with the last two positions indicating the type of beneficiary.
2.	Transaction Code	1	12	12	0-Christian Science SNF 4-Regular SNF
3.	Month and Year of Birth	5	13	17	YYDDD
4.	Sex	1	18	18	1-Male 2-Female 3-Unknown
5.	Race	1	19	19	1-White 2-Negro 3-Other 4-Unknown
6.	Beneficiary's State and County Code	5	20	24	First 2 positions = State code Last 3 positions= County code
7.	SSA-RRB Dual Entitlement Indication	1	25	25	0-No entitlement 1-Has dual entitlement BLANK-Unknown
8.	State Buy-In	1	26	26	0-No 1-Yes
9.	Cross-Reference Account Number	11	27	37	Cross-Reference Account Number (See positions 1-11 for format)
10.	Provider Number	6	38	43	Identification number of the provider submitting the claim.
11.	Admission Date	5	44	48	Date the beneficiary entered the care of the Provider.
12.	Discharge Date	5	49	53	Date the beneficiary left the care of the Provider or died. YYDDD
13.	Age at Admission	3	54	56	

	Information	Number of Positions	Positions BEG	Positions END	Description
14.	Admission Diagnosis	4	57	60	Four position codes indicating the diagnosis upon admission. For a list of the diagnostic codes and their meanings, refer to the manual: International Classification of Diseases, Adapted.
15.	Additional Diagnosis	1	61	61	0-Had no additional diagnoses 1-Had additional diagnoses 9-Unknown
16.	Beneficiary SMSA	5	62	66	SMSA size (pos. 62) SMS Area Code (pos. 63-65) SMS Central City Indication (pos. 66)
17.	Not Used	5	67	71	
18.	Not Used	5	72	76	
19.	Utilization Review Date	5	77	81	Date of review of the patients need for continued SNF care. YYDDD
20.	Benefits Exhausted Date	5	82	86	Date coverage was exhaused YYDDD.
21.	Discharge Status	1	87	87	0-Discharged Alive 1-Died 2-Benefits Exhausted
22.	Formerly Disabled Indication	1	88	88	0-No 1-Yes
23.	Not Used	1	89	89	
24.	Type of Bills Used	1	90	90	1-Initial debit bills only 2-Debit adjustment bills only 3-Initial debit and debit adjustment bills 4-Credit adjustment bills only 5-Initial debit and credit adjustment 6-Debit adjustment and credit adjustment 7-Initial debit, debit adjustment, and credit adjustment
25.	Date Stay Created	4	91	94	MMYY

	Information	Positions	Positions BEG	Positions END	Description
26.	Number of Bills Used For This Stay	2	95	96	Net total of bills used to create stay.
27.	Blank	1	97	97	
28.	Forwarding Date	5	98	102	Date the final bill was forwarded by the hospital to the intermediary. YYDDD
29.	Approval Date	5	103	107	Date the final bill was approved by the intermediary. YYDDD
30.	Date Care Ended	5	108	112	The date of determination by the intermediary that active care, as defined by the Medicare Program, has ended and payment was stopped. YYDDD
31.	Block Number	8	113	120	First 4 positions (113-116) - Julian date the final bill was received in SSA. YDDD Last 4 positions (117-120) - Control number assigned by SSA, the first of which if zoned (117) indicates this bill to be a Mag Tape item.
32.	Batch Number (NNNNYDDD)	8	121	128	First 4 positions (121-124) - Control number assigned to the batch by the intermediary, (NNNN) the first of which if zoned indicates this bill to be a Mag Tape item (121). Fifth position (125) - Y=yr but died Last 3 positions (126-128) - Julian Date batched by the intermediary (DDD).
33.	Providers State and County Code	5	129	133	State and county code of the Provider BLANK - 1/
34.	Providers Standard Metropolitan Statistical Area Code	3	134	136	Refer to the Bureau of the Budget "SMSA" Manuals for a list of the codes and their meanings. BLANK - 1/
35.	Type of Facility	1	137	137	1-Skilled nursing facility 2-Extended care unit of hospital

	Information	Number of Positions	Positions BEG	Positions END	Description
35.	Continued				3-Extended care unit of rehabilitation center 4-Extended care unit of Domiciliary institution 5-Other BLANK-1/
36.	Control	1	138	138	Voluntary Non-Profit 1-Church 2-Other than church 3-Proprietary Government Non-Federal 4-State 5-County 6-City 7-City-County 8-Hospital District Federal Government 9-Public Health Service or other than PHS BLANK-1/
37.	Participation Status	1	139	139	Fully Participating With: 1-No significant deficiency 2-Correctable deficiency(s) 3-Special participation 4-Limited payment BLANK-1/
38.	Number of Nursing Beds	4	140	143	Actual number of nursing beds BLANK-1/
39.	Intermediary Number	5	144	148	Identification number of the intermediary processing the claim. Consult the "Directory of Medical Facilities" for a list of the intermediary numbers.
40.	Guarantee of Payment Date	5	149	153	
41.	Not Used	1	154	154	

	Information	Number of Positions	Positions BEG	Positions END	Description
42.	Accommodations Days and Charges Each code field has a 3 position days field, a 5 position total charges field of dollars only and a 5 position covered charges field of dollars only.	13 13 13	155 168 181	167 180 193	B Field - 1 bed facility C Field - 2-4 bed facility D Field - 5 or more bed facility
43.	Total Accommodation Days	4	194	197	
44.	Covered Charges	5	198	202	Whole dollar amount of covered charges.
45.	Non-Covered Charges	5	203	207	Whole dollar amount of the total non-reimbursable expenses for this stay.
46.	Total Charges	5	208	212	Whole dollar amount of the total of all expenses in this stay.
47.	Services Used and Related Charges Each field has a 1 position code field, a 5 position total charges field of dollars only and a 5 position covered charges field of dollars only. The codes are K thru T.	11 11 11 11 11 11 11 11 11 11	213 224 235 246 257 268 279 290 301 312	223 234 245 256 267 278 289 300 311 322	K Code - Blood Administration L Code - Pharmacy M Code - Radiology N Code - Laboratory O Code - Medical, Surgical and Central Supplies P Code - Physical Therapy Q Code - Occupational Therapy R Code - Speech Therapy S Code - Inhalation Therapy T Code - Other
48.	Amount Not Reimbursed	5	323	327	
49.	Coinsurance Days	3	328	330	Number of coinsurance days used in the stay
50.	Coinsurance Amount	4	331	334	Whole dollar amount of the coinsurance incurred in this stay.
51.	Reimbursement Amount	5	335	339	Whole dollar amount of the total of reimbursable expenses.
52.	Accommodations Total Covered Charges	5	340	344	Whole dollar amount of the covered charges fields from the accommodations.

	Information	Number of Positions	Positions BEG	Positions END	Description
53.	Covered Days	3	345	347	Number of covered days in this stay.
54.	Length of Stay	3	348	350	Total length of the stay.
55.	Medicare Status Code	2	351	352	Two position code to classify a beneficiary under 1972 Amendments. Tens Position: 1=Aged 2=Disabled 3=Chronic Renal Disease Units Position: 0=No CRD 1=CRD
56.	Original Reason for Entitlement)OREC)	1	353	353	Basis for first entitlement to HI benefits. 0=OASI 1=DIB 2=Renal 3=Renal and DIB
57.	Current Reason for Entitlement (CREC)	1	354	354	Basis for beneficiary's current entitlement to HI benefits. 0=OASI 1=DIB 2=Renal 3=Renal and DIB
58.	Renal Insured Status Indicator (RISI) and Prior Unqualifying DIB Indicator (PUDI)	1	355	355	RISI denotes beneficiary's entitlement to HI benefits is based on fully or currently insured worker's earnings and not on beneficiary's own earnings. PUDI denotes beneficiary was previously disabled but not enough to qualify for HI on that basis. 0=Neither 1=RISI 2=PUDI 3=RISI and PUDI
59.	Chronic Renal Disease Indicator (CRDI)	1	356	356	Source of notification of CRD 0=No CRD A=MBR B=HI C=NIH D=MBR/HI E=EBR/NIH

	Information	Number of Positions	Positions BEG	Positions END	Description
59.	Continued				F=HI/NIH G=NBR/HI/NIH
60.	Blanks	17	357	373	
61.	Group Practice Prepayment Plan Code	3	374	376	For a list of the plans refer to: Director of Medical Facilities Blank-1/
62.	Not Used	4	377	380	
63.	Not Used	1	381	381	1=Dollar daily rate 2=Dollar daily rate including all services
64.	Qualifying Stay Date-(From)	5	382	386	From date of stay in a hospital that qualified the claimant for this SNF stay.
65.	Qualifying Stay Date-(To)	5	387	391	To date of qualifying hospital stay.
66.	Blanks	4	392	395	
67.	Record Mark	1	396	396	End of Stay Record.

1/ These fields are not available in the bill records used to create this file. These fields will be initialized to blank or zero. If the information contained in these fields is required, a match to the Provider File will have to be made.

Annual Skilled Nursing Facility Skeleton Record Write-Off

Information	Number of Characters	Positions
HI Claim Number	11	1- 11
Date of Birth	5	12- 16
Sex	1	17
Race	1	18
State of Residence	2	19- 20
County of Residence	3	21- 23
ZIP Code of Residence	5	24- 28
PSRO of Residence	3	29- 31
Provider Number	6	32- 37
County of Provider	3	38- 40
ZIP Code of Provider	5	41- 45
PSRO of Provider	3	46- 48
Date of Admission	5	49- 53
Date of Discharge	5	54- 58
Date Benefits Exhausted	5	59- 63
Discharge Status	1	64
Qualifying Stay "From" Date	5	65- 69
Qualifying Stay "Thru" Date	5	70- 74
Primary Admitting Diagnosis	4	75- 78
Indication of Additional Diagnosis	1	79
Accommodation Covered Charges	5	80- 84
Total Covered Charges	5	85- 89
Coinsurance Days	2	90- 91
Coinsurance Amount	4	92- 95
Amount Reimbursed	5	96-100
Covered Days	3	101-103
Total Days	3	104-106
Medicare Status Code	2	107-108
Age at Date of Admission	3	109-111
Block Number	8	112-119
Batch Number	8	120-127
Blanks	5	128-132

Note 1: All dates are Julian

Note 2: All money fields are rounded to whole dollars

VII. Special Purpose Files

Introduction

This chapter describes several special purpose files which are created for specific projects. These files are created from the detailed billing records and are used to prepare annual publication tabulations and research notes.

Health Insurance Bill Skeleton File for State and County Reimbursement Publication (Exhibit A)

This file is used to create the DHEW annual publication: Reimbursement by State and County. This is an annual Medicare publication with reimbursement amounts based on the year claims are approved for payment by intermediaries or carriers.

For each year, the data are compiled based on an 18 month period. The period begins with the first month of the file year and continues until the cutoff date, 6 months after the file year. The file is created by writing off selected information from each detailed billing record. These skeleton records are then summarized to prepare a record for each county based on the beneficiary's state and county of residence.

Bills for years with claim approved prior to the most current year being tabulated are included in the current year's file. For example, the 1974 annual file contains all bills approved for payment in 1974 that were processed in SSA during the period January 1974 through June 1975. Also included are bills approved for payment in 1973 or earlier processed after June 1974 that were not included in the 1973 file.

Person Summary File (Exhibit B)

This file is used to create the DHEW annual publication: Summary. This is an annual Medicare publication based on persons receiving reimbursed Medicare services in a year. For each year, data are compiled based on a 30 month period. The period begins with the first month of the file year and continues until the cutoff date, 18 months after the file year. Separate files for Inpatient, Skilled Nursing Facility, Home Health Agency-Part A and Part B, Outpatient bills and Payment Records are created from the detailed bill records that contain reimbursement amounts. Bills without reimbursement are not included. Data for aged persons are based on a five percent sample of the billing records and for disabled persons are based on the complete file.

Each of the selected files is sorted individually and then merged to produce one combined, sorted bill-record file for aged and disabled. This combined file is processed against a cross-reference file to combine information for one person who may have bills under two HI claim numbers. The file is then resequenced and split into an aged file and a disabled file. These two files are summarized separately by person to bring together all reimbursed services for that person during the year. As an example, the 1974 Person Summary File is created from all bills with dates of service in 1974 and with amounts reimbursed greater than zero that were processed in SSA during the period January 1974 through June 1976. Note that this file is based on year service incurred, while the State and County Reimbursement File (described above) is based on year claim approved.

PSRO-Hospital Discharge Skeleton File (Exhibit C)

This file is a by-product of our operation which produces semiannual discharge data by Professional Standards Review Organization areas (PSRO's). Hospital discharge bills (100%) are matched to a Provider of Services file to obtain the PSRO area code of the hospital along with State and county codes and ZIP Code. Tabulations by PSRO and hospitals are prepared from this record. These files and tabulations have been prepared for discharges 1974 and afterwards.

Outpatient Bill Skeleton File (Exhibit D)

This file is prepared annually (beginning 1974) for a 5 percent sample of SSA-1483 bills--Provider Billing for Medical and Other Health Services. For each year of service the file is prepared from all bills processed at SSA through the period ending 12 months after the end of the service year. For example the 1976 file is prepared from all outpatient bills processed through December 1977.

Home Health Agency Skeleton File (Exhibit E)

This file is prepared annually (beginning 1975) for a 40 percent sample of SSA-1487 bills--Home Health Agency Report and Billing. For each year of service the file is prepared from all bills processed at SSA through the period ending 12 months after the end of the service year. For example the 1976 file is prepared from all HHA bills processed through December 1977.

Health Insurance Bill Skeleton File
for State and County Reimbursement Publication

	Information	Number of Positions	Location BEG	Location END	Description
1.	Record Identification Code	1	1	1	Code values are: R=Part B Payment Record V-Part A Bill W-Part B Bill
2.	HI Claim Number	11	2	12	SSA number plus beneficiary identification code.
3.	State Code	2	13	14	Where person resides
4.	County Code	3	15	17	Where person resides
5.	Date of Birth	5	18	22	YYDDD
6.	Sex Code	1	23	23	Code values are: 0-Unknown 1-Male 2-Female
7.	Race	1	24	24	Code values are: 0-Unknown 1-White 2-Black 3-Other
8.	Format (RicR)/Form (Ric V&W)	1	25	25	Source of information Format codes are: N-SSA1490 (New Format) O-SSA1490 (Old Format) Form codes are: C-SSA1453 (Inpatient) D-SSA1483 (Outpatient) E-SSA1486 (Christian Science) F-SSA1487 (Home Health) G-Nonpayment Bills (1453, 1486, 1487)

	Information	Number of Positions	Location BEG	Location END	Description
9.	Entry Code (RicR)/Query Code (Ric V&W)	1	26	26	(RICR) Entry Codes A code for type payment record being submitted: 1-Original Debit 2-Supplemental 3-Full Credit 4-Partial Credit 5-Replacement Debit 6-Partial Debit (RIC V&W) Query Code Code indicating status of bill: 1-Interim Bill 2-Visits Exhausted (HHA) 3-Final Bill 4-Discharge Notice (Non-covered Bill) 5-Debit Adjustment 0-Credit Adjustment
10.	Recode Code (RicR)/ Transaction Code (Ric V&W)	1	27	27	(RICR) entry recode Status code indicating that a record is an initial submittal, a resubmittal, an initial reject, or a resubmitted reject. 1, 3, 5, 7, & 9-Initially submitted, accepted record 2, 4, 6, & 8-Resubmitted accepted records A, C, E, & G-Initially submitted, rejected record B, D, F, & H-Resubmitted rejected records X-Acknowledges an A reject previously submitted Transaction code: 0-Christian Science SNF 1-Psychiatric Hospital Facility

	Information	Number of Positions	Location BEG	Location END	Description
					2-Tuberculous Hospital Facility 3-General Care Hospital Facility 4-Regular SNF 5-HHA 6-Outpatient
11.	Date Paid (RicR)/Date Approved (Ric V&W)	5	28	32	YYDDD-If date is Unknown field will contain zero.
12.	Reimbursement Amount	9	33	41	Signed Field, amount reimbursed.
13.	Debit/Credit Value	1	42	42	Tabling value of record.
14.	Medicare Status Code	2	43	44	A beneficiary classification: 10-Aged without ESRD 11-Aged with ESRD 20-Disabled without ESRD 21-Disabled with ESRD 31-ESRD only
15.	Current Reason for HI Entitlement (CREC)	1	45	45	Current basis for entitlement: 0-OASI 1-DIB 2-Renal 3-DIB and Renal
16.	Original Reason for HI Entitlement (OREC)	1	46	46	Original basis for entitlement: 0-OASI 1-DIB 2-Renal 3-DIB and Renal
17.	Data Indicator (RISI-PUDI)	1	47	47	0-All off 1-CRD spouse or child of worker 2-Prior unqualifying DIB 3-Both conditions present
18.	Blank	1	48	48	Reserved for future use.
19.	ZIP Code	5	49	53	ZIP Code
20.	Record Mark	1	54	54	Constant '≠'

Exhibit B

Person Summary File

	Information	Number of Positions	Location BEG	Location END	Description
1.	HI Claim Number	11	1	11	HI-9 digits, 1 or 2 alpha suffix RRB-alpha prefix, 10 digits.
2.	Cross-Reference Claim Number	11	12	22	HI-9 digits, 1 or 2 alpha suffix RRB-alpha prefix, 10 digits.
3.	State Code	2	23	24	Geographic state code
4.	County Code	3	25	27	Standard county code
5.	Medicare Status Code	2	28	29	Aged, no ESRD-10 Aged, with ESRD-11 Disabled, no ESRD-20 Disabled, with ESRD-21 ESRD only-31
6.	Renal Insurance Status Indicator	1	30	30	Worker-0 Others-1, 2, or 3
7.	Beneficiary Status	1	31	31	OASDI-1 RRB-2 Dual-3
8.	Date of Birth	5	32	36	YYDDD
9.	Date of Death	5	37	41	YYDDD 00000-None
10.	Race	1	42	42	White-1 Non-white-2 Unknown-3
11.	Sex	1	43	43	Male-1 Female-2
12.	Age	2	44	45	Aged Age at last birthday as of 07/01/YY if alive at end of year. If person is 64, consider as age 65. Disabled Age at last birthday as of 07/01/YY if alive at end of year. If person is 65, consider as age 64.

	Information	Number of Positions	Location BEG	END	Description
12.	Age (con't)				Aged or Disabled For persons who died, use age on first day of month of death.
13.	Discharge Status	1	46	46	Inpatient: Alive-0 Dead-1 Other-⌀
14.	Not Used	4	47	50	Blanks
		Reimbursement Amounts			
15.	Inpatient Hospital	9	51	59	$$$$$$$¢¢
16.	Skilled Nursing Facility	9	60	68	$$$$$$$¢¢
17.	HHA-Part A	9	69	77	$$$$$$$¢¢
18.	Physician and Other Medical Services	9	78	86	$$$$$$$¢¢
19.	Outpatient	9	87	95	$$$$$$$¢¢
20.	HHA Part B	9	96	104	$$$$$$$¢¢
21.	Total Part A	10	105	114	$$$$$$$$¢¢
22.	Total Part B	10	115	124	$$$$$$$$¢¢
23.	Total Part A and/or Part B	10	125	134	$$$$$$$$¢¢
24.	Part A and Part B	10	135	144	$$$$$$$$¢¢
25.	Part A only	10	145	154	$$$$$$$$¢¢
26.	Part B only	10	155	164	$$$$$$$$¢¢

Exhibit C

PSRO-Hospital Discharge Skeleton Record

	Information	Number of Positions	Positions BEG	Positions END	Description
1.	HI Claim Number	11	1	11	SSA-9 digits, 1 or 2 alpha suffix, RRB alpha prefix, 10 digits
2.	Provider Number	6	12	17	Provider number on bill
3.	Date of Admission	5	18	22	YYDDD
4.	Date of Discharge	5	23	27	YYDDD
5.	Discharge Status	1	28	28	A=Discharged; B=Died
6.	Total Days	3	29	31	Date of Discharge-Date of Admission; if "0" show it as "0" but tabulate as "1" in tables.
7.	Beneficiary State-County Code	5	32	36	SSCCC 2 digit State code, 3 digit county code
8.	Medicare Status Code	2	37	38	Beneficiary classification 10=Aged without ESRD 11=Aged with ESRD 20=Disabled without ESRD 21=Disabled with ESRD 31=ESRD only
9.	Provider State-County Code	5	39	43	SSCCC 2 digit State code, 3 digit county code
10.	Provider ZIP Code	5	44	48	ZIP Code of provider
11.	PSRO Number	5	49	53	SSAAA 2 digit State code, 3 digit area code
12.	Date of Birth 1/	5	54	58	YYDDD
13.	Sex 1/	1	59	59	Sex code 0=Unknown; 1=Male; 2=Female
14.	Race 1/	1	60	60	Race code 0=Unknown; 1=White; 2=Black; 3=Other

	Information	Number of Positions	Positions BEG	END	Description
15.	ZIP Code of Beneficiary 1/	5	61	65	ZIP Code
16.	Blank	1	66	66	Filler

1/ Added to record 03/78

Exhibit D

Outpatient Bill Skeleton Record-5%-Sample

	Information	Number of Positions	Positions BEG	Positions END	Description
1.	HI Claim Number	11	1	11	
2.	Date of Birth	5	12	16	YYDDD
3.	Sex	1	17	17	1=Male; 2=Female
4.	Race	1	18	18	1=White, 2=Non-White; 3=Unknown
5.	State of Residence	2	19	20	State of Residence
6.	County of Residence	3	21	23	County of Residence
7.	ZIP Code of Residence	5	24	28	
8.	Medicare Status Code	2	29	30	10=Aged 11=Aged CRD 20=Disabled 21=Disabled CRD 31=CRD only
9.	Provider Number	6	31	36	
10.	Type of Service	1	37	37	1=Inpatient; 2=Outpatient; 3=Other
11.	Nature of Illness	4	38	41	ICDA-8
12.	Additional Diagnosis Indicator	1	42	42	0=No; 1=Yes; 9=Unknown
13.	Surgical Procedure Code	4	43	46	CPT
14.	Additional Surgery Indicator	1	47	47	0=No; 1=Yes; 9=Unknown
15.	Number of Clinic Visits	2	48	49	
16.	Number of Emergency Room Visits	2	50	51	
17.	Covered Charges				
	A. Clinic Visits	6	52	57	$$$$¢¢
	B. Emergency Room	6	58	63	$$$$¢¢
	C. Laboratory	6	64	69	$$$$¢¢
	D. Radiology	6	70	75	$$$$¢¢
	E. Pharmacy	6	76	81	$$$$¢¢
	F. Blood	6	82	87	$$$$¢¢
	G. Ambulance	6	88	93	$$$$¢¢
	H. Physical Therapy	6	94	99	$$$$¢¢
	I. Total Others	6	100	105	$$$$¢¢

	Information	Number of Positions	Positions BEG	END	Description
18.	Total Covered Charges	6	106	111	$$$$¢¢
19.	Date of Last Service	5	112	116	YYDDD
20.	Amount Reimbursed	6	117	122	$$$$¢¢
21.	Batch Number	8	123	130	
22.	Block Number	8	131	138	
23.	Blanks	8	139	144	

Exhibit E

Home Health Agency Skeleton Record-40%-Sample

	Information	Number of Positions	Positions BEG	Positions END	Description
1.	HI Claim Number	11	1	11	
2.	Date of Birth	5	12	16	YYDDD
3.	Sex	1	17	17	1=Male; 2=Female
4.	Race	1	18	18	1=White, 2=Non-White; 3=Unknown
5.	State	2	19	20	State of Residence
6.	County	3	21	23	County of Residence
7.	ZIP Code	5	24	28	
8.	Medicare Status Code	2	29	30	10=Aged 11=Aged CRD 20=Disabled 21=Disabled CRD 31=CRD only
9.	Provider Number	6	31	36	
10.	Payment Edit RIC	1	37	37	
11.	Diagnostic Code	4	38	41	ICDA-8
12.	Multiple Diagnosis Code	1	42	42	0=No; 1=Yes; 9=Unknown
13.	Period From Date	5	43	47	YYDDD
14.	Period Thru Date	5	48	52	YYDDD
15.	Status Code	1	53	53	A=Discharged; B=Died; C=Still Receiving Services; D-Visits Exhausted
16.	Visits and Charges				
	A. Visits	2	54	55	Number of visits
	A. Charges	6	56	61	$$$$¢¢
	B. Visits	2	62	63	Number of visits
	B. Charges	6	64	69	$$$$¢¢
	C. Visits	2	70	71	Number of visits
	C. Charges	6	72	77	$$$$¢¢
	D. Visits	2	78	79	Number of visits
	D. Charges	6	80	85	$$$$¢¢
	E. Visits	2	86	87	Number of visits
	E. Charges	6	88	93	$$$$¢¢

	Information	Number of Positions	Positions BEG	Positions END	Description
16.	Continued				
	F. Visits	2	94	95	Number of visits
	F. Charges	6	96	101	$$$$¢¢
	G. Visits	2	102	103	Number of visits
	G. Charges	6	104	109	$$$$¢¢
	G1. Visits	2	110	111	Number of visits
	G2. Charges	6	112	117	$$$$¢¢
17.	Total Visits	2	118	119	Total visits for all services
18.	Total Visit Charges	6	120	125	Total charges for all visits
19.	Other Charges	6	126	131	Total K-Charges
20.	Total Charges	6	132	137	Total Charges A-K
21.	Reimbursement Amount	6	138	143	$$$$¢¢
22.	Batch Number	8	144	151	
23.	Master Block Number	8	152	159	
24.	Filler	3	160	162	

VIII. Medicare History Sample File

Introduction

The Social Security Administration's Health Insurance System provides for processing and maintenance of all utilization health insurance bills and payment records, and enrollment records. As a byproduct of this system, individual HCFA statistical files are obtained to provide data bases for all types of information on the health insurance program. However, until the implementation of the Medicare History Sample all requests for "person" data had to be processed by combining various individual files. A more efficient method of obtaining hospital and medical insurance data is to create a sample file consisting of selected fields from the various Medicare bill files on an ongoing scheduled basis. Such a file permits more in depth studies of utilization patterns over extended time periods.

The Medicare History Sample (MHS) file is intended to provide quick access to "person" data. This concept is quite useful because of the different types of beneficiaries now covered. Since selected data for each sample person has been combined into one record, it is not necessary to process many different files to reply to a specific request.

In depth research requests have been extremely difficult to honor because of the multitude of files usually involved in supplying the data. A simple request such as "types of health care involved with a specific surgical procedure" involves large amounts of processing of numerous files. Sample size of the various files also differ. Some are five percent, others are 20 percent, while a few are maintained on a 100 percent basis. The five percent MHS file will reduce the number of files and records that must be processed for a number of types of requests.

Finally, the MHS file, being a combined file and being updated annually, has eliminated the problem of having to refer to old files with old formats. Information for all years obtained (representing services after 1973) are consistent, and fully documented.

Preparation of MHS File

The MHS file is prepared on a five percent sample person basis for years 1974 and later and provides a combined record of all Medicare activity for each year. Selection of beneficiaries to be included in this file is based on the ever-enrolled (1974 and later) concept. Thus any beneficiary enrolled in the Medicare program after 1973 regardless of utilization activity, is represented on this file. Selected personal characteristics are obtained from both the active and inactive HISKEW files. Utilization data for each year are selected from inpatient hospital, inpatient SNF, home health agency and outpatient bills that are processed by Medicare intermediaries and physician service information is obtained from payment records that are processed by Medicare carriers.

Each portion obtained is then combined to form one record for each Medicare beneficiary within the sample on an ongoing basis. Once a beneficiary is included in the MHS sample, that person remains on the file regardless of activity or death. This provides the flexibility for ready access of person data needed to follow utilization patterns of each sample beneficiary.

The initial selection of beneficiaries included in this sample file was based on records obtained from the active and inactive HI Master Enrollment Record

as of the update closest to April 1, 1975, with the following characteristics:

1. Primary and/or cross-reference HI claim number in the 5 percent sample.

2. Current entitlement to hospital insurance benefits (Part A) and/or supplementary medical insurance benefits (Part B) was before January 1, 1975, without current termination before January 1, 1974; i.e., anyone ever enrolled in 1974.

Subsequent updates of additional beneficiaries will continue to be based on entitlement after 1973 and will be obtained annually from the updated Master Enrollment File. In addition to newly entitled beneficiaries, those previously included are reselected for subsequent years enrollment file for use in a current update. This provides the MHS file with current demographic characteristics. An annual segment is appended to the Master Record portion of all active beneficiaries and provides the means for noting changes in benefit status, residency, and type of enrollment. The status and coverage characteristics are based as of July 1 of the reference year.

All sample utilization records (bills and payment records) included in the initial preparation of the MHS were selected from initial debit records processed through June 1975 with services in 1974.

Subsequent annual updates to the MHS included those initial debit utilization records with service dates after December 31, 1973, processed since the prior years file through the current years June update. Thus, when accreting for 1977 activity, only sample records with service dates of 1974-1977 and processed through June 1978 are used. The types of utilization records used to obtain information are as follows:

1. Stay Records

   a. Inpatient hospital stay records representing complete stays

   b. Inpatient SNF stay records representing complete stays or incomplete stays with date benefits exhausted.

The incomplete SNF stay record is replaced in subsequent updates by a complete stay record, when the discharge record for that stay has been processed.

Multiple inpatient hospital or SNF stays for the year, are included in the file.

2. Home health agency, outpatient, and payment records are summarized by type of record on a calendar year basis and included in the annual update of the MHS.

Two additional source files are used to annotate the MHS sample records with information relating to third party and GPPP activity. These data are obtained from the State Buy-In and GPPP member files annually, and identifies those MHS beneficiaries ever enrolled in the reference year as a State Buy-In and/or a member of a GPPP.

Contents of the MHS Record

The complete MHS record varies in size based on whether Medicare utilization is present or not, type of service utilized by the beneficiary, and the number of years involved. The file is maintained in chronological sequence by type of record and by date(s) of service. Exhibit A details each possible type of service present for a MHS beneficiary.

Medicare History Sample Record Contents

Fixed HISKEW Portion 2/

	Information	Dec. Size	Usage 1/		Location		Description
1.	Type of Record	1	X	1	01	01	Blank
2.	Current HIC Number 10/						If RRB, position 02 will be non-numeric.
	a. Account Number	9	X	9	02	10	
	b. Equatable BIC Code	2	X	2	11	12	
3.	Cross-Reference Claim Number 3/						
	a. X-R Account No.	9	X	9	13	21	Blank if no cross-reference number
	b. X-R BIC Code	2	X	2	22	23	
4.	Status of HIC Number 3/	1	X	1	24	24	1. Current number in 5% sample--no cross-reference. 2. Both current and cross-reference numbers in 5% sample. 3. Current number in 5% sample. Cross-reference not in sample. 4. Cross-reference in 5% sample. Current number not in sample. NOTE: For status code 4, records the cross-reference number is placed in the current HI claim number field, while the cross-reference claim number field contains the actual current number, if available.
5.	Dual Entitlement 3/	1	X	1	25	25	0-No dual entitlement 1-Yes dual entitlement
6.	Date of Birth	5	C3	3	26	28	YYDDD
7.	Sex Code	1	X	1	29	29	0-Unknown 1-Male 2-Female
8.	Race Code	1	X	1	30	30	0-Unknown 1-White 2-Black 3-Other

	Information	Dec. Size	Usage 1/		Location		Description
9.	Part 'A' Dates 3/						
	a. Latest entitlement	5	C3	3	31	33	YYDDD
	b. Latest termination	5	C3	3	34	36	YYDDD
	c. Prior entitlement	5	C3	3	37	39	YYDDD
	d. Prior termination	5	C3	3	40	42	YYDDD
10.	Reason for Latest Part 'A' Termination 3/	1	X	1	43	43	Ø-No termination 1-Death 2-Non-payment of premium 3-Voluntary withdrawal 4-Entitled under another number 5-DIB recovery
11.	Part 'B' Dates 3/						
	a. Latest entitlement	5	C3	3	44	46	YYDDD
	b. Latest termination	5	C3	3	47	49	YYDDD
	c. Prior entitlement	5	C3	3	50	52	YYDDD
	d. Prior termination	5	C3	3	53	55	YYDDD
12.	Reason for Latest Part 'B' Termination 3/	1	X	1	56	56	Ø-No termination 1-Death 2-Non-payment of premium 3-Voluntary withdrawal 4-Entitled under another number 5-DIB recovery
13.	Date of Death 3/	5	C3	3	57	59	YYDDD
14.	Original Reason for Entitlement	1	X	1	60	60	0-OASI 1-DIB 2-Renal 3-DIB & Renal
15.	Chronic Renal Disease Indicator	1	X	1	61	61	0-No CRD A-MBR B-HI C-NIH D-MBR & HI E-MBR & NIH F-HI & NIH G-MBR, HI & NIH
16.	Original BIC Code	2	X	2	62	63	

Annual HISKEW Data Portion 4/

	Information	Dec. Size	Usage 1/		Location		Description
1.	Type of Record	1	X	1	01	01	Constant '*'.
2.	Reference Year	2	9	2	02	03	YY
3.	Current Reason for Entitlement	1	X	1	04	04	0-OASI 1-DIB 2-Renal 3-Both DIB & Renal
4.	Medicare Coverage 11/	1	X	1	05	05	0-No coverage or Dead (include beneficiaries whose start date(s) is after reference year) 1-Part A entitlement only 2-Part B entitlement only 3-Both Part A and Part B
5.	Medicare Status Code 11/	2	X	2	06	07	10-Aged without CRD 11-Aged with CRD 20-DIB without CRD 21-DIB with CRD 31-CRD only
6.	Uninsured Status 5/	1	X	1	08	08	1-Uninsured 2-Insured
7.	Residence of Beneficiary						
	a. State	2	X	2	09	10	
	b. County	3	X	3	11	13	
	c. ZIP Code	5	X	5	14	18	
8.	GPPP Plan Number	5	X	5	19	23	Blank if no GPPP plan. Obtained from G.P.P.P. Master file.
9.	State Welfare Buy-In	1	X	1	24	24	1-Yes--State Welfare Buy-In 2-No--State Welfare Buy-In Obtained from third party Master file.

HHA Portion 6/

	Information	Dec. Size	Usage 1/		Location		Description
1.	Type of Record	1	X	1	01	01	Constant 'A'
2.	Reference Year	2	X	2	02	03	YY. Obtained from "Ending Date of Service" fields.
3.	Part 'A' Totals 9/						Based on plan code "P" Part A services
	a. Visits	3	C3	2	04	05	NNN-Accum. total for the year.
	b. Charges (A-I)	5	C3	3	06	08	$$$$$-Accum. total for the year.
	c. Other Service Charges	5	C3	3	09	11	$$$$$-Accum. total for the year.
							Obtained by subtracting charges (A-I) from charges (A-K).
	d. Reimbursement Amount	5	C3	3	12	14	$$$$$-Accum. total for the year.
4.	Part 'B' Totals 9/						Based on plan code "M" Part B services.
	a. Visits	3	C3	2	15	16	NNN-Accum. total for the year.
	b. Charges (A-I)	5	C3	3	17	19	$$$$$-Accum. total for the year.
	c. Other Service Charges	5	C3	3	20	22	$$$$$-Accum. total for the year.
							Charges (A-K) less charges (A-I).
	d. Reimbursement Amount	5	C3	3	23	25	$$$$$-Accum. total for the year.
5.	Patient Status Indicator (Based on the record having the latest status date in the reference year)	1	X	1	26	26	A-Discharged alive B-Died C-Still receiving benefits D-Visits exhausted
6.	Patient Status Date (Based on the record having the latest status date in the reference year)	3	C3	2	27	28	DDD

Outpatient Portion 6/

	Information	Dec. Size	Usage 1/		Location		Description
1.	Type of Record	1	X	1	01	01	Constant 'B'
2.	Reference Year	2	9	2	02	03	YY. Obtained from "Date of Last Service" field.
3.	Outpatient Services						Based on third position of provider number equalling 0, 2, 3, or 4 and type of service code is a 2.(O/P Type)
	a. Number of Bills	3	C3	2	04	05	NNN-Accum. total for the year.
	b. Covered Charges	5	C3	3	06	08	$$$$$-Accum. total for the year.
	c. Reimbursement Amount	5	C3	3	09	11	$$$$$-Accum. total for the year.
4.	Inpatient Services						Based on third position of provider number equalling 0, 2, 3, or 4 and type of service code is a 1 (I/P Type).
	a. Number of Bills	3	C3	2	12	13	NNN-Accum. total for the year.
	b. Covered Charges	5	C3	3	14	16	$$$$$-Accum. total for the year.
	c. Reimbursement Amount	5	C3	3	17	19	$$$$$-Accum. total for the year.
5.	Other Services						Based on all other combinations of third position of provider number and type of service code.
	a. Number of Bills	3	C3	2	20	21	NNN-Accum. total for the year.
	b. Covered Charges	5	C3	3	22	24	$$$$$-Accum. total for the year.
	c. Reimbursement Amount	5	C3	3	25	27	$$$$$-Accum. total for the year.

Payment Record Portion 6/

	Information	Dec. Size	Usage 1/		Location		Description
1.	Type of Record	1	X	1	01	01	Constant 'C'
2.	Reference Year	2	9	2	02	03	YY. Obtained from "Last Expense Date" field.
3.	Non-Hospital Based Services						Based on totals accumulated from records with payment codes O/T 4 or 5.
	a. Number of Records	3	C3	2	04	05	NNN-Accum. total for the year.
	b. Reasonable Charges 7/	5	C3	3	06	08	$$$$$-Accum. total for the year.
	c. Reimbursement Amount	5	C3	3	09	11	$$$$$-Accum. total for the year.
4.	Physician Services						Based on totals accumulated from records with payment codes O/T 4 or 5 and with specialty codes 01-40, 48, 49, 70 or 99.
	a. Number of Records	3	C3	2	12	13	NNN-Accum. total for the year.
	b. Reasonable Charges 7/	5	C3	3	14	16	$$$$$-Accum. total for the year.
	c. Reimbursement Amount	5	C3	3	17	19	$$$$$-Accum. total for the year.
5.	Surgical Services						Based on totals accumulated from records with payment codes O/T 4 or 5 and with specialty codes 01-40, 48-49, 70 or 99 and with type of service code 2.
	a. Number of Records	3	C3	2	20	21	NNN-Accum. total for the year.
	b. Reasonable Charges 7/	5	C3	3	22	24	$$$$$-Accum. total for the year.
	c. Reimbursement Amount	3	C3	3	25	27	$$$$$-Accum. total for the year.
6.	Supplier Services						Based on totals accumulated from records with payment codes O/T 4 or 5 with specialty codes 51-69, 87 or 88.
	a. Number of Records	3	C3	2	28	29	NNN-Accum. total for the year.
	b. Reasonable Charges 7/	5	C3	3	30	32	$$$$$-Accum. total for the year.
	c. Reimbursement Amount	5	C3	3	33	35	$$$$$-Accum. total for the year.

	Information	Dec. Size	Usage 1/		Location		Description
7.	Hospital Services						Based on totals accumulated from records with payment codes 4 or 5.
	a. Number of Records	3	C3	2	36	37	NNN-Accum. total for the year.
	b. Reasonable Charges 7/	5	C3	3	38	40	$$$$$-Accum. total for the year.
	c. Reimbursement Amount	5	C3	3	41	43	$$$$$-Accum. total for the year.
8.	Psychiatric Charges	5	C3	3	44	46	$$$$$-Accum. total for the year.
9.	Unassigned Totals						Based on totals accumulated from records with payment code 2.
	a. Number of Records	3	C3	2	47	48	NNN-Accum. total for the year.
	b. Reimbursement Amount	5	C3	3	49	51	$$$$$-Accum. total for the year.

Inpatient Stay Portion 6/

	Information	Dec. Size	Usage 1/		Location		Description
1.	Type of Record	1	X	1	01	01	Constant 'D'
2.	Reference Year	2	9	2	02	03	YY-Year from field 7-B.
3.	Date of Admission	5	C3	3	04	06	YYDDD
4.	Provider Data						
	a. Number	6	X	6	07	12	
	b. Type	1	X	1	13	13	0-Short-stay 2-Long-stay 3-TB 4-Psychiatric 9-Christian Science E-Emergency F-Federal U-Other
5.	Date Benefits Exhausted	5	C3	3	14	16	YYDDD
6.	Number of Covered Days	3	C3	2	17	18	NNN (Includes lifetime reserve days).
7.	Discharge Data						
	a. Status	1	X	1	19	19	1-Alive--no surgical indicator 2-Dead--no surgical indicator 3-Benefits Exhausted--no surgical indicator A-Alive--surgical indicator B-Dead--surgical indicator C-Benefits Exhausted--surgical indicator
	b. Date	5	C3	3	20	22	YYDDD
	c. Diagnosis	4	X	4	23	26	ICDA code
	d. Additional Diagnosis Indicator	1	X	1	27	27	0-No additional diagnosis 1-Yes, additional diagnosis 9-Unknown additional diagnosis
8.	Surgical Data						
	a. Date	5	C3	3	28	30	YYDDD-00000 if no surgery
	b. Procedure	4	X	4	31	34	CPT code, blank if no surgery
	c. Additional Procedure	1	X	1	35	35	Ø-No surgery involved 0-No additional procedure 1-Additional procedure 9-Unknown additional surgical procedure
9.	Totals						
	a. Charges	5	C3	3	36	38	$$$$$
	b. Non-Covered Charges	5	C3	3	39	41	$$$$$
	c. Deductions	5	C3	3	42	44	$$$$$
	d. Reimbursement Amount	5	C3	3	45	47	$$$$$
10.	Lifetime Reserve Days	3	C3	2	48	49	NNN-Number of lifetime reserve days used in this stay.
11.	Coinsurance Days	3	C3	2	50	51	NNN-Number of coinsurance days used in this stay.

SNF Stay Portion 8/

	Information	Dec. Size	Usage 1/		Location		Description
1.	Type of Record	1	X	1	01	01	Constant 'E'
2.	Reference Year	2	9	2	02	03	YY-Year from field 8.b, if present. Else, field 6.
3.	Admission Date	5	C3	3	04	06	YYDDD
4.	Provider Number	6	X	6	07	12	
5.	Admission Data						
	a. Diagnosis	4	X	4	13	16	ICDA code
	b. Additional Diagnosis	1	X	1	17	17	0-No additional diagnosis 1-Yes, additional diagnosis
6.	Date Benefit Exhausted	5	C3	3	18	20	YYDDD
7.	Number of Covered Days 8/	3	C3	2	21	22	NNN
8.	Discharge Data						
	a. Status	1	X	1	23	23	1-Alive 2-Dead 3-Still patient (used only for benefits exhausted stay where discharge notice not yet received).
	b. Date	5	C3	3	24	26	YYDDD
9.	Qualifying Stay Dates						Dates of Stay in hospital that qualify claimant for SNF
	a. From Date	5	C3	3	27	29	YYDDD
	b. To Date	5	C3	3	30	32	YYDDD
10.	Totals						
	a. Charges	5	C3	3	33	35	$$$$$
	b. Covered Charges	5	C3	3	36	38	$$$$$
	c. Coinsurance Amount	5	C3	3	39	41	$$$$$
	d. Reimbursement Amount	5	C3	3	42	44	$$$$$
11.	Total Estimated Charge Indicator	1	X	1	45	45	0-No 1-Yes
12.	Filler	1	X	1	46	46	Space
13.	Coinsurance Days	3	C3	2	47	48	NNN

Footnotes

1/ 9-Numeric characters
X-Alpha-numeric characters
C3-IBM Packed Decimal Field

2/ This portion is considered fixed since size of this segment will not change.

3/ Recoded, if necessary, during each annual update.

4/ The annual portion will be present for each year account is active. Data obtained during each annual update.

5/ Any beneficiary with the first position of the original BIC code J, K, M or T is considered as uninsured.

6/ All money fields are rounded to the nearest dollar.

7/ Reasonable charges are the sums of Psychiartic charges plus Medical charges.

8/ All benefits exhausted stays (no discharge record) are replaced when the complete stay becomes available. Substitution for a complete stay is made based on match of HI claim number, date of admission and provider number.

9/ Parenthetical characters refer to corresponding letters of Form SSA-1487, HHA Billing Report.

10/ See Exhibit B.

11/ As of July 1 of Reference year.

Equatable BIC Code

The MHS Current HIC number consists of two parts (1) the account number which is a 9 position numeric field and (2) the Beneficiary Identification Code (BIC) which indicates the type of beneficiary involved. Since the beneficiary's status may change (e.g., wife becomes a widow) it is necessary to recognize similar BIC's so that the combining of the various files will not create multiple records for the same account. An equatable BIC routine, developed for this purpose, is described below.

When matching the current HIC number from the administrative records to the HISKEW, all records must match on the entire HIC number field. However, records with identical initial 9 positions but with different BIC codes are considered as equal if the original unequal BIC code are equatable within each of the following groups:

1. SSA Claim Numbers

   (a) A; J_1; J_2; J_3; J_4; M; M_1; T
   (b) B; B_2; B_6; D; D_4; D_6; E; E_1; K_1; K_2; K_3; K_4
   (c) B_1; D_1; D_5; E_4; E_5

2. RRB Claim Numbers

   (a) 10; 80
   (b) 11; 13; 14; 16; 43; 46; 83; 84; 86

For example, where a record from one file shows the original BIC code as an "A" while a corresponding record from another file shows a "T", the record is considered a match if the first 9 positions are equal.

IX. Five Percent Sample Bill Summary Record

Introduction

The Supplementary Medical Insurance Program provides coverage for a variety of medical services for those individuals who are enrolled in the program and have paid the required premium. Reimbursement for covered services is made on the basis of reasonable charge determinations and is generally subject to both an annual deductible and a coinsurance amount. Payments are made directly to the physician/supplier or to the beneficiary after review by the contractor (carrier) designated to process these claims.

Monies expended by carriers are reported to SSA by use of payment records (see Chapter III). These payment records serve a very important administrative and statistical purpose. Each payment record submitted contains coded type and place of service based on the largest single charge present on the bill. For SSA to obtain detailed data on the type and place of health care services covered by this program and for data on total physician charges as compared to reasonable charges for type/place of services the Part B Five Percent Bill Summary Record was created.

Preparation of Sample Bill Summary Records

The information contained on the summary record is based on data obtained from bills submitted to the carrier on Forms SSA-1490, SSA-1490W, SSA-1490U, SSA-1491 and SSA-1556 and any appropriate attachments. A bill is defined as a request for payment from a beneficiary accompanied by one or more itemized statements from a single physician or supplier. The summary record is then prepared for each of these bills where the beneficiary's health insurance claim number falls into the five percent sample. (See Exhibits C and E, Section 5 for copies of forms.)

> Note: Information contained on Form SSA-1554 (Provider Billing for Patient Services by Physician) is not collected because methods of reporting data vary by provider, and are not comparable to other information collected in this system.

A summary record is prepared based on the line items for each bill used by the carrier as input data in preparing the reasonable charge determinations or in preparing the Explanation of Medicare Benefits (EOMB). One summary record is prepared for each sample bill; however, if services on a bill cover overlapping years, separate summary records are prepared for each year. Also, summary records are prepared for each bill regardless of the deductible status of the beneficiary. Summary records are not prepared in the following instances:

1. For bills that are totally disallowed.
2. For bills that are duplicates of a previously submitted summary record.
3. For any adjustments of a previously submitted summary record.
4. For covered Medicare services which are disallowed because of over-utilization.

> Note: Bill summary records do not reflect portions of a bill that represent non-covered services.

When a bill involves the rental of durable medical equipment, (DME), each bill indicating rental fees is included in the summary record. A bill submitted for the purchase of DME is included only once in the summary record, when the claim is first received and shows the total charge for the DME. This applies whether the beneficiary is reimbursed in a lump-sum or by the diary method.

In coding the summary record, if a particular type of service is reported two or more times on an individual bill, these multiple services are combined into a single group of identical services for coding as follows:

1. For type of service, medical care, all items with identical place of service code are combined; otherwise each place of service code is reported separately.

2. For type of service surgery, only two combinations using place of service are possible. They are:

   a. All place of service indicating inpatient hospital are combined.

   b. All other places of service are combined.

3. Each type of service other than medical care or surgery are shown separately regardless of place of service. Where a particular type of service appears two or more times on the same bill, these services are combined.

Where services are grouped as described above, the number of services are counted and related money amounts aggregated. See Exhibit A for Decision Logic Table for the combining and coding of identical services.

After the summary records are prepared carriers process all records through an edit program provided by SSA. This program checks consistency of the data contained in each record and produces a report reflecting the number of errors. Carriers are expected to correct all errors before accumulating and submitting the records monthly to SSA.

Upon receipt at SSA, all summary records are processed in an edit program similar to the one provided the carriers. Any tape containing excessive errors or is unreadable because of read errors is sent back to the carrier. The carrier must then correct the records and resubmit the summary record tape.

Contents of the Bill Summary Record

The summary record is a fixed length record submitted on magnetic tape which provides information identifying the beneficiary, the physician/supplier and detailed data for up to maximum of 17 type and place of service combinations that may be reported on individual bills. All positions of the record are either completed with the appropriate data or left blank if so defined. Exhibit B provides detailed description of each field of the record.

Exhibit A

Decision Logic Table for the Combining and Coding of Identical Types of Service

If Type of Service is	and Place of Service is	Action	Coding of Type of Service	Coding of Place of Service
1	1	Accumulate all data and combine	1	1
1	2	Accumulate all data and combine	1	2
1	3	Accumulate all data and combine	1	3
1	4	Accumulate all data and combine	1	4
1	5	Accumulate all data and combine	1	5
1	7	Accumulate all data and combine	1	7
1	8	Accumulate all data and combine	1	8
2	3	Accumulate all data and combine	2	3
2	1-2, 4-8	Accumulate all data and combine	2	blank
3	Any (1-8)	Accumulate all data and combine	3	blank
4	Any (1-8)	Accumulate all data and combine	4	blank
5	Any (1-8)	Accumulate all data and combine	5	blank
6	Any (1-8)	Accumulate all data and combine	6	blank
7	Any (1-8)	Accumulate all data and combine	7	blank
8	Any (1-8)	Accumulate all data and combine	8	blank
9	Any (1-8)	Accumulate all data and combine	9	blank
0	Any (1-8)	Accumulate all data and combine	0	blank

Five Percent Sample
Bill Summary Record

	Information	Number of Positions	Location BEG	Location END	Description
1.	HI Claim Number	12	1	12	The beneficiary's health insurance claim number. This field is left justified.
2.	Sex	1	13	13	Code: 1-Male 2-Female
3.	First Expense Month	2	14	15	The month of the earliest covered incurred expense. Digits 01-12 for January-December.
4.	Last Expense Month	2	16	17	The month of the most recent incurred covered expense. First expense month repeated if all covered expenses were incurred in the same month. Digits 01-12 for January-December.
5.	Expense Year	1	18	18	Unit position of the year in which expenses were incurred. NOTE: If services overlap years, separate records must be prepared for each year.
6.	Total Submitted Charges for Covered Medicare Services	5	19	23	The total charges for all covered services, rounded to the nearest dollar amount. This field is right justified. NOTE: Field will reflect total covered charges submitted even if later reduced because of a lower reasonable charge determination.
7.	Total Reasonable Charges	5	24	28	The total reasonable charges for all covered services. For outpatient psychiatric expenses, 62½% or $312.50 (whichever is less) of the reasonable psychiatric charges is shown for the items on the request for payment form for which payments have been made. For diary records prepared after the initial payment, no Summary Record is submitted. The field is right justified and rounded to the nearest dollar.

	Information	Number of Positions	Location BEG	Location END	Description
8.	Total Reimbursement	5	29	33	The total amount of payment made to or on behalf of the beneficiary. Blank if all allowed charges are credited to the deductible. This field is right justified and rounded to the nearest dollar.
9.	Deductible Applied	2	34	35	Amount of the incurred expenses in this Summary Record which were applied to the deductible. Round to the nearest dollar amount.
10.	Physician/Supplier Specialty Code	2	36	37	A two-digit code for each physician/supplier dealing with the carrier showing the physician's specialty or type of supplier. Only one specialty code will normally be used for a given physician/supplier.
11.	Physician/Supplier ID Number	9	38	46	1. Social Security Account Numbers--are used for solo-practice physicians and solo-proprietorship suppliers where the request for payment is reimbursed on a fee for service basis. Solo-practicing physicians and/or suppliers are those physicians (suppliers) who bill only for their own services and in their own name. Clinics and other group practices, hospitals, etc., although billing as a single entity, are generally not considered solo practitioners for purposes of this section. However, the social security number of the individual physician is used for physicians in group practice whenever bills are submitted on SSA-1490's in the name of individual physicians. 2. Employer Identification Number--the EI number is used when identifying groups, partnerships, or clinics. EI numbers are also used for independent laboratories, group practice prepayment plans and other entities who

	Information	Number of Positions	Location BEG	Location END	Description
					bill in a group or company's name including physicians billing through a provider as hospital-based physicians. 3. Other Identification Numbers. Unique identification numbers assigned by the carriers are used only if the social security or employer identification number is not available. Such usage should be very limited and occur only until valid social security or EI numbers can be obtained. NOTE: Vendors providing services outside the U.S. are assigned a unique number also. (The provider number assigned by SSA or, if none available, a carrier assigned number.)
12.	Type of Physician/Supplier ID Number Shown in Field 38-46	1	47	47	Code: 1-Physicians or sole-proprietorship suppliers for whom SS numbers are shown in the physician ID code field. 2-Physicians or sole-proprietorship suppliers for whom SS numbers are not available and the carrier's own physician ID code is shown. 3-Suppliers (other than sole-proprietorship) for whom employer identification numbers are used in coding the ID field. 4-Supplier (other than sole-proprietorship) for whom employer ID numbers are not known and the carrier's own code has been shown. 5-Hospitals and independent laboratories for whom EI numbers are used in coding the ID field.

	Information	Number of Positions	Location BEG	Location END	Description
					6-Hospitals and independent laboratories for whom EI numbers are not available and provider numbers assigned by carrier or SSA are shown. 7-Clinics, groups, associations or partnerships for whom EI numbers are used in coding the ID field. 8-Group practice prepayment plans for whom EI numbers are used in coding the ID field. 0-GPPP's for whom EI numbers are not available and the carrier's own physician/ supplier code has been assigned.
13.	Assignment Decision	1	48	48	Coded as follows: 1-Assignment accepted 2-Assignment not accepted 3-All covered expenses applied to deductibe. NOTE: If any part of the Medicare payment was made to the physician/supplier, code 1 is used. If payment was made to the beneficiary only, code 2 is used. Code 3 is used only to indicate that all covered expenses shown are being applied to deductible.
14.	Carrier Number	5	49	53	The number assigned by SSA to each carrier's service area. When a carrier operates in multiple areas, this number indicates the carrier field office handling the physician's/ supplier's bills.
15.	Intermediary Control	10	54	63	The unique control number which is assigned by the carrier to the individual bill. This code will generally be the same number as that assigned to corresponding payment records or (where no payment record is prepared; i.e., deductible not met) the query.

	Information	Number of Positions	Location BEG	END	Description
					NOTE: If the intermediary control number is less than 10 positions, it is right justified.
16.	Type of Request for Payment	1	64	64	Coded as follows: 1-SSA-1490, 1490W, 1490U, 1491 2-SSA-1556 SSA-1554's are not included in sample.
17.	Cancel Indication	1	65	65	All initial records are blank in this position. If a Summary Record has been submitted which should never have been prepared; i.e., services were subsequently disallowed, an identical record is submitted containing a 1 in this position. NOTE: Do not attempt to revise an incorrectly submitted record by using the cancel indication and then resubmitting a new "initial". NOTE: Adjustment records are not used in this project. Only initial or cancel records are prepared by carriers.

NOTE: The appropriate fields below are completed for each separate service or separate group of services (up to a maximum of 17). When a number of separate services or separate group of services is less than 17, the remainder of the record is filled with blanks.

18.	Type of Service Code	1	66	66	This field denotes the type of service that the remaining fields represent. Coded: 1-Medical care 2-Surgery 3-Consultation 4-Diagnostic X-Ray 5-Diagnostic laboratory 6-Radiation therapy 7-Anesthesia 8-Assistance at surgery 9-Other medical service 0-Charges for whole blood or packed red blood cells.

Information	Number of Positions	Location BEG	Location END	Description
				The following definitions of type of service are used in assigning the codes:
				1. Medical Care - Includes all physician services, including those of podiatrists, surgical chiropodists and chiropractors not elsewhere classified and office visits, home visits, nursing home visits, and nonsurgical hospital. Psychiatric services, diagnostic services, allergy testing, therapeutic procedures, special dermatological procedures, and physical medicine services are also included. Consultation is excluded.
				2. Surgery - Includes those procedures recognized in the surgical section of Current Procedural Terminology published by the AMA and services pertaining to incision, excision, repair, suture, destruction, introduction, fractures, manipulation, dislocations, amputation and endoscopy.
				3. Consultation - Refers to the professional service rendered by a physician whose opinion or advice has been requested by another physician or agency for the evaluation and/or treatment of a patient.
				4. Diagnostic X-Ray - X-Ray and related services undertaken for diagnostic purposes.
				5. Clinical Laboratory - Laboratory services, regardless of where rendered, required in the diagnosis of disease or injury. Also includes certain mechanical or machine tests such as EKG, EEG, BMT, etc.
				6. Radiation Therapy - Therapeutic services, such as X-Ray,

Information	Number of Positions	Location BEG	Location END	Description
				radon, radium, and isotopes for the treatment of malignancies, tumors of bones, brain, or spinal cord, angiomas, vascular nevi, lymphomas, leukemia and thyroid disease. 7. Anesthesia - Services for anesthesia including the appropriate pre and post-operative visits, administration of anesthetic, and transfusion of fluid and/or blood incident to the anesthesia or surgery. 8. Assistance at Surgery - Surgical assistance rendered upon the request of the primary surgeon and governed by the rules for such services prescribed by the carrier. 9. Other Medical Services - Services falling in the following special categories: a. Rental, purchase or repair of durable medical equipment. b. Internal and external prosthetic devices and appliances. c. Supplies d. Ambulance services 0. Charges for Whole Blood or Packed Red Blood Cells - Includes bills where the charges are for whole blood or packed red blood cells and where reimbursement is made.
19. Place of Service Code	1	67	67	This field denotes the place of service. If the type of service indicated is medical care, place of service can be any of the codes listed below. If the type of service is surgery, only (inpatient hospital), place of service is coded. All other place of services are left blank. For all other types of service this field will be blank.

	Information	Number of Positions	Location BEG	Location END	Description
					"1"-Office "2"-Home "3"-Inpatient hospital "4"-Skilled nursing facilities "5"-Outpatient hospital "7"-Other "8"-Limited care facilities - Free standing centers of satellite units of hospitals for treatment of kidney disease. NOTE: Code 5 is used for services in a clinic which is part of a hospital. Code 1 is used for all other clinics.
20.	Service Charge(s)	5	68	72	The total charges for each separate service or group of services. This field is right justified and rounded to the nearest dollar.
21.	Service Reasonable Charge	5	73	77	The total reasonable charge for each separate service or group of services. Rounded to the nearest dollar amount and right justified.
22.	Number of Services	2	78	79	This field is completed only for types of service code 1 thru 9. If type of service code is 0 (Part B blood), this field is not coded. A service is defined as a procedure having a separate reasonable charge determination. One service is coded 01. If two or more identical services are being combined, the total number of services is entered, i.e., 02 through 99.
23.	Additional Type and Place of Service	238	80	317	All fields from "Type of Service Code-18" through "Number of Services-22" (14 positions) are repeated for up to 17 different types of service--Place of Service Combinations. See Exhibit A for Decision Logic Table for possible combinations. NOTE: Last 14 positions reserved for future expansion.

X. Provider of Services Master File

Introduction

Institutional providers of service (hospitals, SNF's, etc.), participate in the Medicare and Medicaid programs through a formal certification procedure which examines the institution's qualifications for furnishing safe and effective care for the beneficiaries of the two programs. The certification procedure is conducted by an agency of the government of the State where the institution is located under guidelines and final approval determined by the Medicare Bureau and the Public Health Service. After the initial certification, the qualifications of an institution are reviewed at least annually; culminating in a decision to retain or terminate participation.

Source Documents and Input

The observations and decisions of the State agency surveyors when applying the various criteria, which measure an institution's capability of providing acceptable care, as well as characteristics such as staffing, bed size, and services are recorded in a forms package. This forms package is divided into two sets: the first, called the survey report form (SRF), contains the criteria and the decisions of a surveyor in applying the criteria to the particular institution. The second set comprises the source documents for the Provider of Services Master (POS) File and includes the certification and transmittal (Exhibit A) and the application (Exhibit B). A separate version of the application form is used for each type of provider (hospital, SNF, HHA, etc.).

The complete forms package (POS and SRF) is converted on a flow basis to magnetic disk in the regional office where the files of the original source documents are maintained.

Update Mechanism and Quality Control Measures

The update cycle for the POS/SRF system is daily. Once a day the keyed data from all the regions are wire transmitted directly to BDP. The keyed data are sorted, and a transaction record (accretion, correction, termination) is built by combining all the POS and SRF data elements into a single record for each provider of service. This record is then passed through a series of computer consistency checks which examine the record for such error possibilities as dates outside acceptable ranges, disagreement of provider number with type of facility indicators, absence of staffing to provide services indicated, incorrect codes, and many others. Exhibit D depicts the record contents of the POS portion for hospitals and SNF's. During this phase of the update system, a segment indicating errors discovered is appended to the transaction record.

The transaction record is then match/merged to an orbit file of earlier transactions which could not be applied to the master data base due to an error, and await correction by the regional office. New transactions are added to the orbit file, corrections overlay the matching orbit record.

Next, the orbit file is passed against the POS-SRF master data base: accretions without error are added to the data base; recertifications replace the associated earlier certifications, which are placed on a separate history file; corrections

and termination actions overlay or add the prescribed data elements to the existing record. All new transactions including those that failed to pass the consistency checks, those that failed to match the master data base, and those that were successfully applied to the master data base are transmitted over the telecommunication network to the regional offices. The entire process is set to a daily schedule so that the regions receive the disposition of the records they originally transmitted the morning following their transmission to central office.

In addition to the computer consistency checks, OPPR performs monthly a manual check of selected fields of all transactions applied to the POS portion of the master data base. ORS also does a manual review of the POS source documents. Periodic notices are sent to the regions showing erroneous transactions which are still uncorrected and on the orbit file after a specified time period.

Dependent Systems and Outputs

The POS file is used to support a number of Health Insurance administrative data processing systems. These include the following:

1. The Directory of Medical Facilities

   This is a compendium of participating and non-participating medical care institutions which is used primarily by the intermediaries for admission approval and spell-of-illness determination.

2. The Update of the Provider Master File

   The POS file furnishes provider records to this system which posts bill information to the records to produce the Provider Statistical and Reimbursement Report and the Provider Monitor Listing. The former is used as an audit tool at time of cost settlement and the latter for program review.

3. Provider Cost Report Monitoring System

   The POS file serves as a control file for this system which monitors the progress of cost reports through the various stages of audit and settlement.

4. Prospective Limits on Provider Costs

   The POS file is used for addressing information and provider characteristics such as bed size and geographic location which are factors in the grouping of providers for computing limits of reimbursable costs by the Division of Reimbursement and Accounting Policy, Medicare Bureau.

5. Provider Cost Statement System

   The POS file is matched to the data captured from the cost statements to produce the cost statement master file. Outputs include identification of providers which are out-of-line in specified cost criteria.

OPPR publishes recurring tabulations and analyses based on information from the POS file on a quarterly and an annual basis. Various listings and tabulations have been produced to satisfy requests from private organizations, other components

of HCFA and DHEW, and the Congress. Exhibit C is the output format of a general listing program which is used most frequently to respond to special requests. A version of the POS tape file is also prepared in a format suitable for use as input to the table generating TABGEN software package, which is another means of servicing one-time special requests.

Exhibit A

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Form Approved
OMB No. 72-R072S

MEDICARE/MEDICAID
CERTIFICATION AND TRANSMITTAL

TO BE COMPLETED BY STATE SURVEY AGENCY

3. NAME AND ADDRESS OF FACILITY (L3)

(L4)

(L5) (L6)

4. TO DHEW REGIONAL OFFICE

TO TITLE XIX SINGLE STATE AGENCY

5. CATEGORY OF PROVIDER / SUPPLIER (L7)

01 ☐ Gen. Hosp. 05 ☐ HHA 09 ☐ Chronic Dialysis Unit
02 ☐ Psych. Hosp. 06 ☐ Independent Lab
03 ☐ TB Hosp. 07 ☐ Portable X-Ray 10 ☐ ICF
04 ☐ SNF 08 ☐ Outpatient PT/SP 11 ☐ IMR

6. TYPE OF ACTION (L8)

1 ☐ Initial 4 ☐ Change of Ownership
2 ☐ Recertification 5 ☐ JCAH/AOA Validation
3 ☐ Reconsideration 6 ☐ JCAH/AOA Investigation

7. DATE OF APPLICATION *(Initial certifications ONLY)* (L9)

8. ACCREDITATION VERIFIED *(Hospitals)* (L10) 1 ☐ JCAH 2 ☐ AOA

CHANGE IN ACCREDITATION-BASED CERTIFICATION *(Hospitals)*

1 ☐ Gained Accreditation 2 ☐ Lost JCAH Accreditation
3 ☐ Lost AOA Accreditation

(L11)

1. MEDICARE PROVIDER NUMBER (L1)

2. MEDICAID ID NUMBER (L2)

10. PURSUANT TO PROVISIONS OF SEC. 1864 AND APPLICABLE PROVISIONS OF TITLE XIX OF THE SOCIAL SECURITY ACT AND UPON CONSIDERATION OF ALL FACTS THE FACILITY IS CERTIFIED AS (L12)

(a) ☐ In compliance with program requirements *(If appropriate, check applicable boxes below)*

Compliance is based on

(1) ☐ Acceptable P.O.C.
(2) ☐ CFR sec. 405.1010 (Access provisions)
(3) ☐ P.L. 91-690 (24 Hour RN)
(4) ☐ 1861(j)(15)(7 day RN rural SNF)

and/or approved waiver(s) of the

following requirements

(5) ☐ Life Safety Code
(6) ☐ ANSI (Std. A 117.1)
(7) ☐ Organized Medical Staff
(8) ☐ Patient Room Size
(9) ☐ Beds Per Room

(b) ☐ Not in compliance with program requirements *(If Title XIX only, complete item 13)*

(c) ☐ Reapproval Deferred Until _____ *(See Remarks)*

(d) ☐ SNF/ICF Cancellation Date is:
(1) ☐ Invoked
(2) ☐ Rescinded

11. SNF / ICF PERIOD OF CERTIFICATION (L13)

(a) FROM (b) TO

(c) CANCELLATION DATE (SNF/ICF) (L14)

12. SUPPLEMENTAL INFORMATION ON HOSPITALS AND SNF'S NOT IN COMPLIANCE (L15)

(a) Hospital meets emergency services hospital definitions (1) ☐ Yes (2) ☐ No

(b) Facility meets 1861(e) (1) - Definition of hospital (1) ☐ Yes (2) ☐ No

(c) Facility meets 1861(j) (1) - Definition of SNF

(1) ☐ Yes (2) ☐ No (3) ☐ See attached SSA 1539 (a)

13. SUPPLEMENTAL ICF INFORMATION (L16)

(a) Completion date for ICF/LSC compliance

(b) 249.13 ICF Phase in Date

14.

TOTAL OR DISTINCT PART CERTIFICATION	HOSPITALS	XVIII SNF	XVIII/XIX SNF	XIX SNF	XIX ICF	XIX IMR
BEDS CERTIFIED (L17)	(a)	(b)	(c)	(d)	(e)	(f)
BEDS PREVIOUSLY CERTIFIED (L18)	(g)	(h)	(i)	(j)	(k)	(l)

15. STATE SURVEY AGENCY REMARKS

16. SURVEYOR SIGNATURE 17. DATE (L19)

TITLE

18. STATE SURVEY AGENCY APPROVAL 19. DATE (L20)

TITLE

TO BE COMPLETED BY THE DHEW REGIONAL OFFICE OR SINGLE STATE AGENCY

20. DETERMINATION OF ELIGIBILITY (L21)

1 ☐ Facility is eligible to participate
2 ☐ Facility is not (or no longer) eligible to participate *(If Title XIX only, complete Item No. 26)*

21. ☐ Facility is in compliance with Title VI of Civil Rights Act (L22)

22. ☐ Statement of financial solvency filed in accordance with regulation 405.603 (L23)

23. EFFECTIVE DATE OF *(Enter All Applicable)*

(a) PARTICIPATION (L24)

(b) AGREEMENT ENDING DATE (SNF) (L25)

(c) CANCELLATION DATE (SNF) (L26)

(d) SNF/ICF AGREEMENT EXTENDED UNDER SEC. 1866(d)(1)(C) OF SOCIAL SECURITY ACT UNTIL (MAXIMUM OF 60 DAYS) (L27)

(e) TERMINATION OR NON RENEWING DATE (L28)

(f) EMERGENCY SERVICES (L29)

24. VOLUNTARY TERMINATION (L30) 1 ☐ CLOSURE 2 ☐ WITHDRAWAL 3 ☐ OTHER *(Specify)*

25. INTERMEDIARY NUMBER (L31)

26. REMARKS

27. PHS REVIEW *(Where applicable)*

28. DATE (L32)

29. DETERMINATION APPROVED

30. DATE (L33)

1 FM SSA-1539 (11-71) OFFICE OF RESEARCH & STATISTICS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Form Approved
OMB No. 72-R07.27

LONG-TERM CARE FACILITY REQUEST TO ESTABLISH ELIGIBILITY IN THE MEDICARE AND/OR MEDICAID PROGRAM

All facilities desiring to establish eligibility in the program(s) should complete this form and return it to the State agency that is handling the certification process. If a return envelope is not provided, the name and address of the State agency may be obtained from the nearest Social Security Administration district office, or the Title XIX Single State Agency.

PROVIDER IDENTIFICATION

PROVIDER NUMBER (N1)	MEDICAID ID NO. (N2)
STATE/COUNTY (N3)	STATE REGION (N4)
PHS REGION (N5)	PSRO (N6)

I. Identifying Information

NAME OF FACILITY | STREET ADDRESS

CITY, COUNTY, AND STATE | ZIP CODE | TELEPHONE NUMBER *(Including Area Code)* (N7)

NAME AND ADDRESS OF PARENT ORGANIZATION *(If chain affiliated)* (N8) | NAME OF ADMINISTRATOR (N9) | LICENSE NO. (N10) | FISCAL YEAR ENDING DATE (N11)

II. Licensure

(N12) 1 ☐ LICENSED OR APPROVED AS NAME OF AGENCY
BY A STATE OR LOCAL GOVERNMENT AGENCY

2 ☐ NO LICENSE OR APPROVAL REQUIRED BY STATE LAW

3 REQUEST TO ESTABLISH ELIGIBILITY IN (N13) 1) ☐ MEDICARE 2) ☐ MEDICAID 3) ☐ BOTH

III. Type of Facility *(Check one)* (N14)

01 ☐ Skilled Nursing Facility
02 ☐ Skilled Nursing Unit of Hospital
03 ☐ Skilled Nursing Unit of Rehabilitation Center
04 ☐ Skilled Nursing Unit of Domiciliary Inst.
05 ☐ SNF Distinct Part of Skilled Nursing Facility
06 ☐ Christian Science San.
07 ☐ General ICF
08 ☐ ICF Distinct Part of Skilled Nursing Facility
09 ☐ SNF-ICF (Swing Bed)
10 ☐ IMR
11 ☐ Other *(Specify)* _____

IV. Type of Control *(Check one)* (N15)

Voluntary Non-Profit
1 ☐ Church
2 ☐ Other *(Specify)*
3 Proprietary ☐
Government *(Non-Federal)*
4 ☐ State 6 ☐ City 8 ☐ Hospital District
5 ☐ County 7 ☐ City-County
9 ☐ Other *(Specify)* _____

V. Services Provided: BY STAFF, Place a "1" in the block(s). If UNDER ARRANGEMENT, place a "2" in the block(s). (N16)

01 ☐ Nursing
02 ☐ Physical Therapy
03 ☐ Outpatient Physical Therapy
04 ☐ Occupational Therapy
05 ☐ Speech Pathology
06 ☐ Outpatient Speech Pathology
07 ☐ Social Services
08 ☐ Recreational Activities
09 ☐ Pharmacy
10 ☐ Clinical Laboratory
11 ☐ Diagnostic X-ray
12 ☐ Administration and Storage of Blood
13 ☐ Dentistry
14 ☐ Podiatry
15 ☐ Ophthalmology
16 ☐ Psychological Services
17 ☐ Other *(Specify)* _____

VI. Please See Instructions

1 REGISTERED PROFESSIONAL NURSES (N17) (a) (b)	5 QUALIFIED SPEECH PATHOLOGISTS (N21) (a) (b)	9 MEDICAL RECORDS PRACTITIONERS (N25) (a) (b)
2 LICENSED PRACTICAL NURSES (N18) (a) (b)	6 LICENSED PHARMACISTS (N22) (a) (b)	10 DIETITIANS (N26) (a) (b)
3 QUALIFIED PHYSICAL THERAPISTS (N19) (a) (b)	7 QUALIFIED SOCIAL WORKERS (N23) (a) (b)	11 ALL OTHERS (N27) (a) (b)
4 QUALIFIED OCCUPATIONAL THERAPISTS (N20) (a) (b)	8 OTHER SOCIAL WORK PERSONNEL (N24) (a) (b)	

SIGNATURE OF AUTHORIZED OFFICIAL | TITLE | (N28) DATE

FORM SSA-1516 (12-75)

PROVIDER OF SERVICES 760430 REQUESTED 760416

PROV NO 056497 X-REF NO PARENT NO INT NO 50051 CERT DATE 751107 APPROV DATE 751205 MEDICAID NO

FIRST CARE CENTER - NORTH
700 NORTH FIRST STREET
BURBANK CA 91502
ANDREW FIRSTENBERG

SCC 05019 PSRO TYPE FAC 01 TERM DATE TERM CODE
DOC TYPE CONT 03 CANC DATE 760229
PHS STATUS A FROM DATE 751107 TO DATE 760630
SMSA BEDS 70 EXTEN DATE

--EMPLOYEES--

	RPN	LPN	PHYS TH	OCC TH	SP PATH	PHARM	SOC WR	OTH SW	MED RCD	DIET	OTHER
TOTAL	1.50	5.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
DP	1.50	5.50	0.00	0.00	0.00	0.00	0.00	0.50	0.00	0.00	27.50

SERVICE 12002021222222220

****

PROV NO 056498 X-REF NO PARENT NO INT NO 00040 CERT DATE 750707 APPROV DATE 751203 MEDICAID NO

BALDWIN PARK CONVALESCENT HOSPITAL
14518 E LOS ANGELES STREET
BALDWIN PARK CA 91706
MRS PRCHAL

SCC 05019 PSRO TYPE FAC 01 TERM DATE TERM CODE
DOC TYPE CONT 03 CANC DATE 760331
PHS STATUS A FROM DATE 750707 TO DATE 760731
SMSA BEDS 49 EXTEN DATE

--EMPLOYEES--

	RPN	LPN	PHYS TH	OCC TH	SP PATH	PHARM	SOC WR	OTH SW	MED RCD	DIET	OTHER
TOTAL	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
DP	1.50	2.75	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	22.00

SERVICE 12020021222222200

****

PROV NO 056499 X-REF NO PARENT NO INT NO 99990 CERT DATE 751001 APPROV DATE 751222 MEDICAID NO

SHEA CONVALESCENT HOSPITAL
4320 MARICOPA STREET
TORRANCE CA 90503
LYNN HUNTER

SCC 05019 PSRO TYPE FAC 01 TERM DATE TERM CODE
DOC TYPE CONT 03 CANC DATE
PHS STATUS A FROM DATE 751001 TO DATE 760630
SMSA BEDS 124 EXTEN DATE

--EMPLOYEES--

	RPN	LPN	PHYS TH	OCC TH	SP PATH	PHARM	SOC WR	OTH SW	MED RCD	DIET	OTHER
TOTAL	0.00	3.25	0.00	1.00	0.00	0.00	0.00	0.50	0.00	0.00	46.25
DP	0.00	3.25	0.00	1.00	0.00	0.00	0.00	0.50	0.00	0.00	46.25

SERVICE 12012021222022220

****

Provider of Services Hospital Record

Exhibit D

	Information	Number of Positions	Location BEG	Location END	Description
1.	Type of Record	1	1	1	Always contains a P.
2.	Provider Number	6	2	7	Six position number identifies a specific facility. First two positions are the State code. Positions 3 and 4 are coded as follows: 00-08--short-stay hospital 09--multi hospital complex 18--neighborhood health center 19--Christian Science 20-24--long-stay 30-34--tuberculosis 40-49--psychiatric D0-D9--denied participation M0-M9--not participating but meets Medicare definition of a hospital P0-P9--not participating and does not meet Medicare definition of a hospital. Positions 5 and 6 are numeric except for emergency and federal hospitals which are coded E & F, respectively.
3.	Intermediary Number	5	8	12	Five position number identifying the hospital's intermediary.
4.	Effective Date of Participation	6	13	18	Six position date (YR-MO-DA) hospital entered Medicare program.
5.	Date of Application	6	19	24	Six position date (YR-MO-DA) when hospital initially applied for participation.
6.	Surveyor Date	6	25	30	Six position date (YR-MO-DA) when State surveyor completed examination of hospital.
7.	State Survey Agency Approval Date	6	31	36	Six position date (YR-MO-DA) State agency approved survey of hospital.
8.	Termination Date	6	37	42	Six position date (YR-MO-DA) hospital was terminated from program.

	Information	Number of Positions	Location BEG	END	Description
9.	Determination Approved Date	6	43	48	Six position date (YR-MO-DA) Regional office approved State findings.
10.	PHS Review Date	6	49	54	Six position date (YR-MO-DA) Public Health Service reviewed survey.
11.	Category of Provider	2	55	56	Coded as follows: 01-General hospital 02-Psychiatric hospital 03-TB hospital 09-Christian Science
12.	Type of Action	1	57	57	Coded as follows: 1-Initial certification 2-Recertification 3-Reconsideration 4-Change of Ownership 5-Validation 6-Investigation
13.	Eligibility Determination	1	58	58	Coded as follows: 1-Eligible 2-Ineligible to participate
14.	Title VI Compliance	1	59	59	Coded as follows: 1-In compliance Blank-No information
15.	Statement of Financial Solvency	1	60	60	Coded as follows: 1-Statement filed Blank-No information
16.	Reason for Termination Code	1	61	61	Coded as follows: 1-Voluntary closure, merger 2-Voluntary withdrawal 3-Involuntary 4-Change of ownership (CHOW) 5-New owner elects not to participate 6-CHOW, new number assigned 7-Failure to abide by agreement 8-Emergency hospital changed to full participation

	Information	Number of Positions	Location BEG	Location END	Description
17.	Supplemental Informations or Hospitals not in Full Compliance	2	62	63	Coded as follows: A1-Emergency hospital A2-Not emergency hospital B1-Meets Medicare definition B2-Does not meet Medicare definition
18.	Status of Compliance with Program Requirements	10	64	73	Information available upon request.
19.	Certified Beds	6	74	79	Code A followed by number of beds right justified and zero filled.
20.	Beds Previously Certified	6	80	85	Code G followed by number of beds right justified and zero filled.
21.	Name of Facility	38	86	123	
22.	Street Address	38	124	161	May be blank.
23.	City and State	33	162	194	
24.	ZIP Code	5	195	199	
25.	Orbit Code	1	200	200	Programmer's use.
26.	Type of Hospital	2	201	202	Coded as follows: 01-General short term 02-General long term 03-Tuberculosis 04-Psychiatric 05-Chronic disease 06-Specialty short term 07-Specialty long term 08-Christian Science 09-Other
27.	Type of Control	2	203	204	Coded as follows: 01-Church 02-Other voluntary non-profit 03-Proprietary 04-State 05-County 06-City 07-City/County 08-Hospital district 09-Federal
28.	State Code	2	205	206	

	Information	Number of Positions	Location BEG	END	Description
29.	County Code	3	207	209	
30.	State Region Code	3	210	212	May be blank in those States not regionalized.
31.	Hospital Service Area Code (HSA)	3	213	215	
32.	PSRO Code	4	216	219	
33.	Public Health Service Code (PHS)	3	220	222	No longer maintained, replaced by HSA code.
34.	Authorized Date	6	223	228	Six position date (YR-MO-DA) when application was completed.
35.	Telephone Number	10	229	238	Can be blank. 3-Area 3-Exchange 4-Number
36.	Fiscal Year Ending Date	4	239	242	Four position date (MO-DA) on which fiscal year ends.
37.	Name of Chief Administrative Officer	26	243	268	Can be blank, left justified.
38.	Previous Intermediary Number #1	5	269	273	Number of intermediary immediately prior to present one.
39.	Previous Intermediary Number #2	5	274	278	Prior to previous intermediary #1.
40.	Switch Date of Intermediary	6	279	284	Six position date (YR-MO-DA) of last intermediary change.
41.	Intermediary Type	1	285	285	Coded as follows: 0-BHI 1-Blue Cross 2-Group health 3-Commercial 4-State agency 5-Other
42.	Provider Number of Parent Organization	6	286	291	Numeric or blank.

	Information	Number of Positions	Location BEG	END	Description
43.	Previous Provider	6	292	297	If the institution changed status; e.g., long term to short term, the previous provider number is placed here.
44.	Status Code	1	298	298	Coded as follows: A-Accretion (initial) record C-Change or correction including resurvey D-Delete T-Terminated
45.	Last Transaction Code	1	299	299	Indicates the last transaction: I-Initial R-Resurvey 9-Correction
46.	Participation Code	1	300	300	Indicates program participation: 1-Medicare 2-Medicaid 3-Medicare and Medicaid 0-Non-participation
47.	Facility Group	1	301	301	Coded as follows: 1-Hospital 2-Long term care 3-Home health agency 4-Physical therapy 5-Independent laboratory 6-Portable X-Ray 7-Chronic renal dialysis
48.	Region	2	302	303	SSA region
49.	SMSA	3	304	306	Standard metropolitan statistical area code
50.	SSA District Office Code	3	307	309	
51.	Run Date of Accretion	6	310	315	Six position date (YR-MO-DA) when initial record entered system.
52.	Run Date of Last Transaction	6	316	321	Six position date (YR-MO-DA) last transaction entered system.

	Information	Number of Positions	Location BEG	END	Description
53.	Change of Ownership	2	322	323	Number of times the facility has changed ownership.
54.	Resurvey Count	2	324	325	Number of resurveys conducted under present ownership.
55.	For Programmer's Use	8	326	333	
56.	Parent Organization Indicator	1	334	334	Coded as follows: 1-Parent organization 2-Subordinate b-No affiliation
57.	For Programmer's Use	43	335	377	
58.	Intern Program	3	378	380	Coded 1 for approval, 0 for not approved or no program. First position-AMA, second position-ADA, third position-AOA.
59.	Licensure	1	381	381	Coded as follows: 1-Licensed 2-No license required
60.	Utilization Review Plan	1	382	382	Coded as follows: 1-Hospital staff 2-Medical society/foundation committee 3-Combination of 1 and 2 4-Other
61.	Medical Staff by Specialty: 1-Surgery 2-Internal medicine 3-Pathology 4-General practice 5-Radiology 6-Obstetrics-Gynocology 7-Urology 8-Pediatrics 9-Gastro-intestinal 10-Neurology 11-Orthopedics 12-Psychiatry 13-Eye, ear, nose and throat 14-Anesthesiology 15-Oral surgery	15	383	397	1-Specialty 0-No specialty

	Information	Number of Positions	Location BEG	END	Description
62.	Blanks	3	398	400	Reserved for expansion.
63.	Beds				Five position, right justified, zero filled.
	Total	5	401	405	
	Adult	5	406	410	
	Pediatric	5	411	415	
	ICU/CCU	5	416	420	
	Nursery	5	421	425	
64.	Facilities and Services	33	426	458	Coded as follows:
	1-Blood bank				1-Provided by staff
	2-Clinical laboratory				2-Provided under arrangement
	3-Pathology laboratory				0-Not provided
	4-Electrocardiograph				
	5-Electroencephalograph				
	6-Pharmacy				
	7-Occupational therapy department				
	8-Physical therapy department				
	9-Intensive care unit				
	10-Organized outpatient department				
	11-Emergency care				
	12-Home care unit				
	13-Operating room				
	14-Post operative recovery room				
	15-Medical social service department				
	16-X-Ray, diagnostic				
	17-Nuclear medicine				
	18-Cobalt and radiation therapy				
	19-Psychiatric and inpatient care unit				
	20-Rehabilitation unit				
	21-Extended care unit				
	22-Renal dialysis				
	23-Open heart surgery				
	24-Coronary care unit				
	25-Oral surgery				
	26-Obstetrics-Gynocology department				
	27-Pediatric department				
	28-Speech therapy department				
	29-Pulmonary function department				
	30-Organ bank				
	31-Ambulatory pre-operative unit				
	32-Nursery				
	33-Shock trauma				
65.	Blanks	3	459	461	Reserved for expansion.
66.	ESRD services	2	462	463	Coded as follows:
	1-Kidney transplant				1-Service is provided
	2-Dialysis				0-Service not provided

	Information	Number of Positions	Location BEG	END	Description
67.	Medical Staff				Four position fields, right justified, zero filled.
	Active	4	464	467	
	Consulting	4	468	471	
	Courtesy	4	472	475	
	Intern	4	476	479	
	Resident	4	480	483	
	Total	4	484	488	
68.	Number of Employees				Six position fields, four whole numbers, two deimals, right justified, zero filled.
	Registered nurse	6	489	494	
	Licensed practical nurse	6	495	500	
	Nurse anesthesiologist (CNRA)	6	501	506	
	Psychiatric nurse	6	507	512	
	Nurse practitioner	6	513	518	
	Midwife	6	519	524	
	Registered record administrator	6	525	530	
	Assistant record technician	6	531	536	
	Medical technician	6	537	542	
	Laboratory technologist	6	543	548	
	Laboratory technician	6	549	554	
	Dietitian	6	555	560	
	Nutritionist	6	561	566	
	Pharmacist	6	567	572	
	Social worker	6	573	578	
	Occupational therapist	6	579	584	
	Speech therapist	6	585	590	
	Physical therapist	6	591	596	
	Physical therapist aide	6	597	602	
	Nurses aide	6	603	608	
	Orderly	6	609	614	
	Physician assistant	6	615	620	
69.	Affiliation with a Medical School	1	621	621	Coded as follows: 1-Major 2-Limited 3-Graduate 4-No affiliation
70.	Number of Resident Programs Approved				Three two position fields right justified, zero filled.
	AMA	2	622	623	
	ADA	2	624	625	
	AOA	2	626	627	
71.	Accreditation Verified	1	628	628	Coded as follows: 1-JCAH accredited 2-AOA accredited

	Information	Number of Positions	Location BEG	END	Description
71.	Con't				Blank-No information or not accredited.
72.	Change in Accreditation	1	629	629	Coded as follows: 1-Gained accreditation 2-Lost JCAH accreditation 3-Lost AOA accreditation Blank-No change
73.	Date Approved for Emergency Services	6	630	635	Six position data (YR-MO-DA) completed for hospitals with E in sixth position of provider number.
74.	Kidney Transplants	3	636	638	Not maintained.
75.	Living Doners	3	639	641	Not maintained.
76.	Cadaver Doners	3	642	644	Not maintained.
77.	Tissue Typing	4	645	648	Not maintained.
78.	Perfusion	4	649	652	Not maintained.
79.	Dialysis Units	3	653	655	Not maintained.
80.	Radiology Laboratory Indicator	1	656	656	Coded as follows: 1-Offers radiology lab service 0 or Blank-Does not offer service.
81.	Emergency Electron Code (Emergency Hospitals Only)	1	657	657	Coded as follows: B-Emergency hospital does not elect participation S-Emergency hospital elects participation
82.	Emergency Election Year	2	658	659	Year election is made, above.
83.	Distinct Part Indicator	1	660	660	D indicates hospital is a distinct part of a larger institution.
84.	Emergency Cross-Reference Provider Number	6	661	666	Former emergency provider number of a hospital now fully participating.

Provider of Services SNF Record

	Information	Number of Positions	Location BEG	Location END	Description
1.	Long Term Care Record	1	1	1	Always contains a P.
2.	Provider Number	6	2	7	Six position number identifies a specific facility. First two positions are State code. Positions 3 and 4 are coded as follows: 50-54, 60-64: Medicare participating SNF's. 69: Christian Science A0-A9, B0-B9: Medicaid only participating SNF's. E0-E9, F0-F9: Medicaid participating ICF's. G0-G9: Medicaid participating IMR's. R0-R9: Non-participating, does not meet definition of a SNF. X0-X9, and Y0-Y9: Non-participating, meets definition of a SNF. Positions 5 and 6 are always numeric.
3.	Intermediary Number	5	8	12	Five position number identifying the Medicare intermediary for a participating SNF.
4.	Effective Date of Participation	6	13	18	Six position date (YR-MO-DA) SNF entered Medicare program.
5.	Date of Application	6	19	24	Six position date (YR-MO-DA) when SNF initially applied for participation.
6.	Surveyor Date	6	25	30	Six position date (YR-MO-DA) when State surveyor completed examination of SNF.
7.	State Survey Agency Approval Date	6	31	36	Six position date (YR-MO-DA) State agency approved survey of SNF.

	Information	Number of Positions	Location BEG	Location END	Description
8.	Termination or Non-Renewing Date	6	37	42	Six position date (YR-MO-DA) SNF was terminated from Medicare program or contract was not renewed.
9.	Determination Approved Date	6	43	48	Six position date (YR-MO-DA) regional office approved State findings.
10.	PHS Review Date	6	49	54	Six position date (YR-MO-DA) Public Health Service reviewed survey.
11.	Category of Provider	2	55	56	Coded as follows: 04-SNF 09-Christian Science 10-ICF (Intermediate care facility) 11-IMR (institution for the mentally retarded)
12.	Type of Action	1	57	57	Coded as follows: 1-Initial certification 2-Recertification 3-Reconsideration 4-Change of ownership 5-Validation 6-Investigation
13.	Eligibility Determination	1	58	58	Coded as follows: 1-Eligible 2-Ineligible to participate
14.	Title VI Compliance	1	59	59	Coded as follows: 1-In compliance Blank-No information
15.	Statement of Financial Solvency	1	60	60	Coded as follows: 1-Statement filed Blank-No information
16.	Reason for Termination Code	1	61	61	Coded as follows: 1-Voluntary closure, merger 2-Voluntary withdrawal 3-Involuntary, no longer meets requirements 4-Change of ownership (CHOW) 5-New Owner elects not to participate

	Information	Number of Positions	Location BEG	Location END	Description
16.	Con't.				6-CHOW, new number assigned 7-Failure to abide by agreement 8-Emergency hospital changed to full participation
17.	Supplemental Information on Facilities not in Full Compliance	2	62	63	Coded as follows: C1-Meets definition of a SNF C2-Does not meet definition C3-Part of facility meets definition of a SNF
18.	Status of Compliance with Program Requirements	10	64	73	Coded indicatiors showing basis for compliance to regulations defining SNF's. Details available upon request.
19.	Certified Beds	6	74	79	One position code: B-Medicare SNF C-Medicare/Medicaid SNF D-Medicaid SNF E-ICF F-IMR Followed by 5 position number of beds right justified, zero filled.
20.	Beds Previously Certified	6	80	85	Coded H, I, J, K, L to correspond to certified beds code followed by 5 position field, right justified, zero filled.
21.	Name of Facility	38	86	123	
22.	Street Address	38	124	161	May be blank.
23.	City and State	33	162	194	
24.	ZIP Code	5	195	199	
25.	Orbit Code	1	200	200	Programmer's use
26.	Type of LTC Facility	2	201	202	Coded as follows: 01-SNF 02-SNF unit of hospital 03-SNF unit of rehabilitation center 04-SNF unit of domiciliary institution.

	Information	Number of Positions	Location BEG	END	Description
26.	Con't.				05-SNF distinct part of SNF 06-Christian Science 07-General ICF 08-ICF distinct part of SNF 09-SNF/ICF (swing bed) 10-IMR 11-Other
27.	Type of Control	2	203	204	Coded as follows: 01-Church 02-Other non-profit 03-Proprietary 04-State 05-County 06-City 07-City/County 08-Hospital district 09-Other
28.	State Code	2	205	206	
29.	County Code	3	207	209	
30.	State Region Code	3	210	212	May be blank in those States not regionalized.
31.	HSA Code	3	213	215	
32.	PSRO Code	4	216	219	
33.	Public Health Service Code (PHS)	3	220	222	No longer maintained, replaced by HSA code.
34.	Authorized Date	6	223	228	Six position date (YR-MO-DA) when application was completed.
35.	Telephone Number	10	229	238	Can be blank. 3-Area, 3-Exchange, 4-Number
36.	Fiscal Year Ending Date	4	239	242	Four position date (MO-DA) on which fiscal year ends.
37.	Name of Chief Administrative Officer	26	243	268	Can be blank, left justified.
38.	Previous Intermediary Number #1	5	269	273	Number of intermediary immediately prior to present one.
39.	Previous Intermediary Number #2	5	274	278	Prior to previous intermediary #1

Information	Number of Positions	Location BEG	Location END	Description
40. Switch date of Intermediary	6	279	284	Six position date (YR-MO-DA) of last intermediary change.
41. Intermediary Type	1	285	285	Coded as follows: 0-BHI 1-Blue Cross 2-Group health 3-Commercial 4-State agency 5-Other
42. Provider Number of Parent Organization	6	286	291	Numeric or blank.
43. Previous Provider Number	6	292	297	If the institution changed status, e.g., IMR to SNF, the previous provider number is placed here.
44. Status Code	1	298	298	Coded as follows: A-Accretion (initial) record C-Change or correction including resurvey D-Delete T-Terminated
45. Last Transaction Code	1	299	299	Indicates the last transaction: I-Initial R-Resurvey 9-Correction
46. Participation Code	1	300	300	Indicates program participation: 1-Medicare 2-Medicaid 3-Medicare and Medicaid 0-Non-participating
47. Facility Group	1	301	301	Coded as follows: 1-Hospital 2-Long term care 3-Home health agency 4-Physical therapy 5-Independent laboratory 6-Portable X-Ray 7-Chronic renal dialysis
48. Region	2	302	303	SSA region.
49. SMSA	3	304	306	Standard metropolitan statistical area code.

	Information	Number of Positions	Location BEG	END	Description
50.	SSA District Office Code	3	307	309	
51.	Run Date of Accretion	6	310	315	Six position date (YR-MO-DA) when initial record entered system.
52.	Run Date of Last Transaction	6	316	321	Six position date (YR-MO-DA) last transaction entered system.
53.	Change of Ownership Count	2	322	323	Number of times the facility has changed ownership.
54.	Resurvey Count	2	324	325	Number of surveys conducted under present ownership.
55.	For Programmer's Use	8	326	333	
56.	Parent Organization Indicator	1	334	334	Coded as follows: 1-Parent organization 2-Subordinate b-No affiliation
57.	For Programmer's Use	46	335	380	
58.	Licensure	1	381	381	Coded as follows: 1-Licensed 2-No license required
59.	Program Eligibility	1	382	382	Coded as follows: 1-Medicare 2-Medicaid 3-Both
60.	Number of Employees in Certified Part				Six position fields, 4 whole numbers, 2 decimals, right justified, zero filled.
	Registered professional nurse	6	383	388	
	Licensed practical nurse	6	389	394	
	Qualified physical therapists	6	395	400	
	Qualified occupational therapists	6	401	406	
	Qualified speech pathologists	6	407	412	
	Licensed pharmacists	6	413	418	
	Qualified social workers	6	419	424	
	Other social work personnel	6	425	430	
	Medical records practioner	6	431	436	
	Dietitians	6	437	442	
	All others	6	443	448	

	Information	Number of Positions	Location BEG	END	Description
61.	Administrator	12	449	460	Can be blank or numeric
62.	Services	17	461	477	Coded as follows:
	1-Nursing 2-Physical therapy 3-Outpatient physical therapy 4-Occupational therapy 5-Speech pathology 6-Outpatient speech pathology 7-Social services 8-Recreational activities 9-Pharmacy 10-Clinical laboratory 11-Diagnostic X-Ray 12-Administration and storage of blood 13-Dentistry 14-Podiatry 15-Ophthalmology 16-Psychological services 17-Other				1-Provided by staff 2-Provided under arrangement 0-Not provided
63.	Blanks	3	478	480	Held for expansion
64.	Medicaid ID Number	12	481	492	Can be blank.
65.	Completion Date for ICF Life Safety Code Compliance	6	493	499	Code "A" followed by 6 position date (YR-MO-DA).
66.	ICF Phase in Date	6	500	506	Code "B" followed by 6 position date (YR-MO-DA).
67.	SNF/ICF Period of Certification				
	From Date	6	507	512	Six position date (YR-MO-DA).
	To Date	6	513	518	Six position date (YR-MO-DA).
68.	SNF/ICF Cancellation Date	6	519	524	Six position date (YR-MO-DA) when contract with SNF/ICF is cancelled. Can be blank.
69.	Agreement Ending Date	6	525	530	Six position date RO designates as date Medicare contract ends.
70.	Cancellation Date	6	531	536	Six position date (YR-MO-DA) RO designates for cancellation of Medicare contract.

	Information	Number of Positions	Location BEG	END	Description
71.	SNF/ICF Agreement	6	537	542	Six position date (YR-MO-DA) beyond normal ending date granted to correct deficiencies.
72.	Distinct Part Indicator	1	543	543	Coded as follows: 1-Facility contains a certified distinct part. 2-Facility does not contain a certified distinct part.
73.	Provider Number of Participating Distinct Part	6	544	549	If 543 is a 1, must have an all numeric entry; otherwise it is blank.
74.	Title XIX Medicaid Participation Indicator	1	550	550	Coded as follows: 1-Participates 2-Does not participate
75.	Total Facility Participates in Medicaid	1	551	551	Coded as follows: 1-Yes 2-No
76.	Number of Medicaid Beds	5	552	556	If position 550 is a "1", a numeric entry; if not, blanks.
77.	Spell-of-Illness Certification	1	557	557	Coded as follows: 1-Meets Medicare definition of an SNF. 2-Does not meet Medicare definition of an SNF.
78.	Source of Spell-of-Illness Certification	1	558	558	Coded as follows: 1-Licensure 2-Contact with institution 3-Other
79.	Number of Beds--Total Facility	5	559	563	Numeric or blank.
80.	Number of Occupied Beds Total Facility	5	564	568	Numeric or blank.
81.	Blanks	2	569	570	

	Information	Number of Positions	Location BEG	END	Description
82.	Number of Employees Entire Facility				Six position fields, 4 whole numbers, 2 decimals, right justified, zero filled.
	Registered professional nurse	6	571	576	
	Licensed practical nurse	6	577	582	
	Qualified physical therapist	6	583	588	
	Qualified occupational therapists	6	589	594	
	Qualified speech pathologist	6	595	600	
	Licensed pharmacists	6	601	606	
	Qualified social workers	6	607	612	
	Other social work personnel	6	613	618	
	Medical records practicioner	6	619	624	
	Dietitians	6	625	630	
	All others	6	631	636	

	Information	Number of Positions	Location BEG	Location END	Description
1.	Type of Record	1	1	1	Always contains a P.
2.	Provider Number	6	2	7	Six position number identifies a specific facility. First two positions are the State code. Positions three and four are coded as follows: 70-77 individual HHA; 78 subunit of a State-wide HHA. Positions five and six are numeric.
3.	Intermediary Number	5	8	12	Five position number identifying the HHA's intermediary.
4.	Effective Date of Participation	6	13	18	Six position date (YR-MO-DA) when HHA entered Medicare program.
5.	Date of Application	6	19	24	Six position date (YR-MO-DA) when HHA initially applied for participation.
6.	Surveyor Date	6	25	30	Six position date (YR-MO-DA) when State surveyor completed examination of HHA.
7.	State Agency Survey Approval Date	6	31	36	Six position date (YR-MO-DA) State agency approved survey of HHA.
8.	Termination Date	6	37	42	Six position date (YR-MO-DA) HHA was terminated from the program.
9.	Determination Approved Date	6	43	48	Six position date (YR-MO-DA) regional office approved state findings.
10.	PHS Review Date	6	49	54	Six position date (YR-MO-DA) Public Health Service reviewed survey.
11.	Category of Provider	2	55	56	Coded 05 for HHA.
12.	Type of Action	1	57	57	Coded as follows: 1-Initial certification 2-Recertification 3-Reconsideration 4-Change of ownership 5-Validation 6-Investigation

	Information	Number of Positions	Location BEG	Location END	Description
13.	Eligibility Determination	1	58	58	Coded as follows: 1-Eligible 2-Ineligible to participate
14.	Title VI Compliance	1	59	59	Coded as follows: 1-In compliance blank-No information
15.	Statement of Financial Solvency	1	60	60	Coded as follows: 1-Statement filed blank-No information
16.	Reason for Termination Code	1	61	61	Coded as follows: 1-Voluntary closure, merger 2-Voluntary withdrawal 3-Involuntary 4-Change of ownership (CHOW) 5-New owner elects not to participate 6-CHOW, new number assigned 7-Failure to abide by agreement 8-Emergency hospital changed to full participation
17.	For Programmer's Use	24	62	85	
18.	Name of Facility	38	86	123	
19.	Street Address	38	124	161	May be blank.
20.	City and State	33	162	194	
21.	ZIP Code	5	195	199	
22.	Orbit Code	1	200	200	Programmer's use.
23.	Type of HHA	2	201	202	Coded as follows: 01-Visiting nurse association 02-Combination government and voluntary agency 03-Official health agency 04-Rehabilitation facility based program 05-Hospital based program 06-SNF based program 07-Proprietary 08-Private nonprofit

	Information	Number of Positions	Location BEG	END	Description
23.	Con't.				09-Other
24.	Type of Control	2	203	204	Coded as follows: 01-Voluntary nonprofit other than church 02-Church 03-State government 04-Local government 05-Combination government and voluntary 06-Proprietary 07-Other 09- State health agency (central) with sub units
25.	State Code	2	205	206	
26.	County Code	3	207	209	
27.	State Region Code	3	210	212	May be blank in those States not regionalized.
28.	Blank	3	213	215	
29.	PSRO Code	4	216	219	Two position State, two position serial.
30.	Blanks	3	220	222	
31.	Authorized Date	6	223	228	Six position date (YR-MO-DA) when application was completed.
32.	Telephone Number	10	229	238	Can be blank, 3-Area, 3-Exchange, 4-Number.
33.	Fiscal Year Ending Date	4	239	242	Four position date (MO-DA) on which fiscal year ends.
34.	Name of Chief Administrative Officer	26	243	268	Can be blank, left justified.
35.	Previous Intermediary Number #1	5	269	273	Number of intermediary immediately prior to present one.
36.	Previous Intermediary Number #2	5	274	278	Prior to previous intermediary #1.
37.	Switch Date of Intermediary	6	279	284	Six position date (YR-MO-DA) of last intermediary change.

	Information	Number of Positions	Location BEG	END	Description
38.	Intermediary Type	1	285	285	Coded as follows: 0-BHI 1-Blue Cross 2-Group Health 3-Commercial 4-State agency 5-Other
39.	Provider Number of Parent Organization	6	286	291	Numeric or blank.
40.	Previous Provider Number	6	292	297	If the institution changed status, e.g., SNF to HHA, the previous provider number is placed here.
41.	Status Code	1	298	298	Coded as follows: A-Accretion (initial) record C-Change or correction including resurvey D-Delete T-Terminated
42.	Last Transaction Code	1	299	299	Indicates the last transaction: I-Initial R-Resurvey 9-Correction
43.	Participation Code	1	300	300	Indicates program participation: 1-Medicare 2-Medicaid 3-Medicare and Medicaid 0-Non participation
44.	Facility Group	1	301	301	Coded as follows: 1-Hospital 2-Long term care 3-Home health agency 4-Physical therapy 5-Independent laboratory 6-Portable X-Ray 7-Chronic renal dialysis
45.	Region	2	302	303	SSA Region
46.	SMSA	3	304	306	Standard metropolitan statistical area.

	Information	Number of Positions	Location BEG	END	Description
47.	SSA District Office Code	3	307	309	
48.	Run Date of Accretion	6	310	315	Six position date (YR-MO-DA) when initial record entered system.
49.	Run Date of Last Transaction	6	316	321	Six position date (YR-MO-DA) last transaction entered system.
50.	Change of Ownership Count	2	322	323	Number of times the facility has changed ownership.
51.	Resurvey Count	2	324	325	Number of resurveys conducted under present ownership.
52.	For Programmer's Use	8	326	333	
53.	Parent Organization Indicator	1	334	334	Coded as follows: 1-Parent organization 2-Subordinate blank-No affiliation
54.	For Programmer's Use	46	335	380	
55.	Area of Operation	1	381	381	Coded as follows: 1-Less than county wide 2-Single county 3-Multi county 4-Unknown
56.	Blank	1	382	382	
57.	Number of Employees				Six position fields, 4 whole numbers, 2 decimals, right justified, zero filled.
	Registered professional nurse	6	383	388	
	Licensed practical nurse	6	389	394	
	Qualified physical therapist	6	395	400	
	Qualified occupational therapist	6	401	406	
	Qualified speech pathologist or audiologist	6	407	412	
	Home health aides	6	413	418	
	Qualified medical social workers	6	419	424	
	Other	6	425	430	